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EMERGENCY HEALTH PERSONNEL ACT AMENDMENTS OF 1972

HEARING

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-SECOND CONGRESS

SECOND SESSION

ON

H.R. 16755, H.R. 16545, H.R. 16869, and S. 3858

BILLS TO AMEND THE PUBLIC HEALTH SERVICE ACT TO IMPROVE THE PROGRAM OF MEDICAL ASSISTANCE TO AREAS WITH HEALTH MANPOWER SHORTAGES, AND FOR OTHER PURPOSES

SEPTEMBER 28, 1972

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EMERGENCY HEALTH PERSONNEL ACT AMENDMENTS OF 1972

THURSDAY, SEPTEMBER 28, 1972

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 2:30 p.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order, please.

I apologize, but we had a vote just prior to this hearing, and that is why we are late getting started.

The hearings today are on H.R. 16755, introduced by myself and Mr. Satterfield, Mr. Kyros, Mr. Preyer, Mr. Symington, Mr. Roy, Mr. Nelsen, Mr. Carter, and Mr. Hastings, and related bills. H.R. 16755 provides for a 3-year extension of the Emergency Health Personnel Act of 1970, Public Law 91–623. The Emergency Health Personnel Act created the National Health Service Corps with a mandate for providing needed health personnel and services in communities of the United States with critical shortages of health manpower. After a rather slow beginning, this program has begun to provide services in needy communities throughout the country. At the present time, 250 health professionals are providing service in 108 needy communities. The response to this program has been overwhelmingly favorable. There have been both numerous requests for assistance and, to date, a good supply of health professionals who are willing to provide their services.

The authorization for this legislation is due to expire at the end of the present fiscal year, June 30, 1973. We understand that physicians, dentists, and other health professionals who will be needed for the program in the next fiscal year are making their plans for that time during these months. For this reason, as well as the widespread public concern for this program, we are considering extension of the legislation at this time in the hope of assuring the program's future and facilitating manpower recruitment for the program.

While the program has clearly been a success, the committee is aware of several areas in which many people feel there is a need for some change and improvement. These include program staffing and budget, manpower supplies for the program, community identification and selection, and the nature of the NHSC's commitment to selected communities. Some of the issues involved have been dealt with in H.R. 16755, and we hope to discuss these and others at today's hearing.

This bill contains an additional important feature. As you know, this subcommittee is charged with the responsibility for the Public Health Service hospitals in this country. To date, the general position of the Congress has been that the PHS hospitals and clinics should be viewed as assets of the Federal Government, with a great potential for service. The general position of the administration—and past administrations—has been to explore the efficacy of transfer or closure with an obvious view toward decreasing Federal involvement. This uncertainty has resulted in chaos for hospital employees and beneficiaries.

This bill is intended to bring an end to the uncertainty of the role of the hospitals and clinics. It provides, first, that if a critical shortage area is served by a PHS hospital or clinic, that facility shall be used to support the provision of care and services by National Health Service Corps personnel, with priority, however, for beneficiaries of the facility. Secondly, the bill would require that a PHS facility may not be closed unless the Congress has been notified at least 90 days in advance, thus affording it a chance to veto the action, and that the notification contain assurances that the PHS beneficiaries and persons receiving care under the Emergency Health Personnel Act will continue to receive equivalent care. I believe that this proposal provides a satisfactory solution to this issue and satisfies the interests of the Congress and the administration—and most importantly, the beneficiaries entitled to care at the facilities.

(The text of H.R. 16755, H.R. 16545, H.R. 16869 and S. 3858, and agency report thereon follow:)

92D CONGRESS
2D SESSION

H. R. 16755

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 21, 1972

Mr. ROGERS (for himself, Mr. SATTERFIELD, Mr. KYROS, Mr. PREYER of North Carolina, Mr. SYMINGTON, Mr. ROY, Mr. NELSEN, Mr. CARTER, and Mr. HASTINGS) introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act to improve the program of medical assistance to areas with health manpower shortages, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. This Act may be cited as the "Emergency Health Personnel Act Amendments of 1972".

SEC. 2. (a) Section 329(a) of the Public Health Service Act is amended to read as follows:

"SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this section referred to as the 'Corps') which shall consist of those officers of the Regular and Reserve Corps of the Serv-

ice and such other personnel as the Secretary may designate and which shall be utilized by the Secretary to improve the delivery of health care and services to persons residing in areas which have critical health manpower shortages."

(b) Section 329(b) of such Act is amended to read as follows:

"(b)(1) The Secretary shall (A) designate those areas which he determines have critical health manpower shortages, (B) provide assistance to persons seeking assignment of Corps personnel to such designated areas to provide under this section health care and services for persons residing in such areas, and (C) conduct such information programs in such designated areas as may be necessary to inform the public and private health entities serving those areas of the assistance available under this section.

"(2)(A) The Secretary may assign personnel of the Corps to provide, under regulations prescribed by the Secretary, health care and services for persons residing in an area designated by the Secretary under paragraph (1) if—

"(i) the State health agency of each State in which such area is located or the local public health agency or any other public or nonprofit private health entity in such area requests such assignment, and

"(ii) such request is approved by the local government of such area and by the State and the district medi-

cal societies in that area or by such other appropriate health societies as the Secretary may designate.

Corps personnel shall be assigned to such areas on the basis of the extent of the areas' need for health care and services and without regard to the ability of the residents of the areas to pay for health care and services.

"(B) In providing health care and services under this section, Corps personnel shall utilize the techniques, facilities, and organizational forms most appropriate for the area and shall, to the maximum extent feasible, provide such care and services (i) to all persons in such area regardless of the ability of such persons to pay for the care and services, and (ii) in connection with (I) direct health care programs carried out by the Service; (II) any direct health care program carried out in whole or in part with Federal financial assistance; or (III) any other health care activity which is in furtherance of the purposes of this section.

"(C) Any person who receives health care or services provided under this section shall be charged for such care or service at a rate established by the Secretary, pursuant to regulations, to recover the reasonable cost of providing such care or service; except that if such person is determined under regulations of the Secretary to be unable to pay such charge, the Secretary shall provide for the furnishing of such care or service at a reduced rate or without charge. If a

Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of the care or service provided under this section if such care or service had not been provided under this section, the Secretary shall collect from such agency or third party the portion of such cost for which it would be so responsible. Any funds collected by the Secretary under this subparagraph shall be deposited in the Treasury as miscellaneous receipts."

(c) Section 329(c) of such Act is amended by striking out "Service" and inserting in lieu thereof "Corps".

(d) Section 329(d) of such Act is amended—

(1) by striking out "Service" in the first sentence and inserting in lieu thereof "Corps", and by inserting before the period at the end of such sentence the following: ", except that if such area is being served (as determined under regulations of the Secretary) by a hospital or other health care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make to insure the availability in such area of care and services by Corps personnel, arrange for the utilization of such hospital or facility by Corps personnel in providing care and services in such area but only to the extent that such utilization will not impair the delivery of care and treatment through such

hospital or facility to persons who are entitled to care and treatment through such hospital or facility";

(2) by striking out "If there are no such facilities in such area" in the second sentence and inserting in lieu thereof "If there are no health facilities in or serving such area";

(3) by adding after the second sentence the following new sentence: "In providing such care and services, the Secretary may (A) make such arrangements as he determines are necessary for the use of equipment and supplies of the Service and for the lease or acquisition of other equipment and supplies, and (B) secure the temporary services of nurses and allied health professionals."; and

(4) by inserting "(1)" after "(d)" and by adding at the end the following:

"(2) The Secretary shall conduct at medical and nursing schools and other schools of the health professions and training centers for the allied health professions, recruiting programs for the Corps. Such programs shall include the wide dissemination of written information on the Corps and visits to such schools by personnel of the Corps".

(e) Section 329(f) of such Act is amended (1) by striking out "Service" in paragraphs (1) and (3) and inserting in lieu thereof "Corps", and (2) by striking out "to

select commissioned officers of the Service and other personnel" in paragraph (2) and inserting in lieu thereof "to select personnel of the Corps".

(f) Subsection (g) of section 329 of such Act is redesignated as subsection (h) and the following new subsection is inserted after subsection (f) of such section:

"(g) The Secretary shall report to Congress no later than May 15 of each year—

"(1) the number of areas designated under subsection (b) in the calendar year preceding the year in which the report is made as having critical health manpower shortages and the number of areas which the Secretary estimates will be so designated in the calendar year in which the report is made;

"(2) the number and types of Corps personnel assigned in such preceding calendar year to areas designated under subsection (b), the number and types of additional Corps personnel which the Secretary estimates will be assigned to such areas in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps; and

"(3) the number of applications filed in such preceding calendar year for assignment of Corps personnel under this section and the action taken on each such application".

(g) Section 329 (g) of such Act is amended by striking out "and" after "1972;" and by striking out the period at the end and inserting in lieu thereof "; $25,000,000 for the fiscal year ending June 30, 1974; $30,000,000 for the fiscal year ending June 30, 1975; and $35,000,000 for the fiscal year ending June 30, 1976."

SEC. 3. (a) The Secretary may not close or transfer control of a hospital or other health care delivery facility of the Public Health Service unless—

(1) he transmits to each House of Congress, on the same day and while each House is in session, a detailed explanation (meeting the requirements of subsection (b)) for the proposed closing or transfer, and

(2) a period of ninety calendar days of continuous session of Congress has elapsed after the date on which such explanation is transmitted.

For purposes of paragraph (2), continuity of session is broken only by an adjournment of Congress sine die, and the days on which either House is not in session because an adjournment of more than three days to a day certain are excluded in the computation of the ninety-day period.

(b) Each explanation submitted under subsection (a) for closing or transferring control of a hospital or other health care delivery facility of the Public Health Service shall—

(1) contain (A) assurances that persons entitled to treatment and care at the hospital or other facility proposed to be closed or transferred and persons for whom care and treatment at such hospital or other facility is authorized will, after the proposed closing or transfer, continue to be provided equivalent care and treatment through such hospital or other facility, and (B) an estimate of the cost of providing such care and treatment to such persons after the proposed closing or transfer;

(2) contain (A) assurances that residents of areas designated under section 329 (b) as critical health manpower shortage areas who are receiving health care and treatment through the hospital or other facility proposed to be closed or transferred will continue to be provided such care and treatment, and (B) a detailed explanation of how such persons will be provided such care and treatment after the proposed closing or transfer;

(3) contain (A) assurances that any teaching program conducted at the hospital or other facility proposed to be closed may be conducted at other appropriate facilities, and (B) a detailed explanation of how such program will be conducted after the proposed closing or transfer; and

(4) have the approval of (A) each agency of a

State which administers or supervises the administration of a State's health planning functions under a State plan approved under section 314(a) of the Public Health Service Act which covers (in whole or in part) the area in which the hospital or other facility is located or which is served by the hospital or other facility, and (B) each public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan, or other local area plan or plans referred to in section 314(b) of such Act and covering (in whole or in part) such area.

SEC. 4. Section 741(f) of the Public Health Service Act is amended (1) by striking out "The payments" in paragraph (2) and inserting in lieu thereof "Except as otherwise provided in this paragraph, the payments", and (2) by adding after and below subparagraph (C) the following: "In the case of any individual who qualified under paragraph (1) for payments on the principal of and interest on a loan and who, as a member of the National Health Service Corps, practices his profession in an area designated under section 329(b), the portion of the principal of and interest on the loans for which payments may be made for and on his behalf under paragraph (1) shall, upon completion of the first year of such practice, be 50 per centum

and, upon completion of the second year of such practice, be the remaining 50 per centum."

SEC. 5. Title II of the Public Health Service Act is amended by redesignating the section 223 of that title entitled "Defense of Certain Malpractice and Negligence Suits" as section 224 and by adding after that section the following new section:

"SCHOLARSHIPS

"SEC. 225. (a) To encourage students at schools of medicine, osteopathy, and dentistry to become commissioned officers of the Regular Corps upon completion of their professional training, the Secretary may make in accordance with this section scholarship grants for study at such schools.

"(b) To qualify for a scholarship grant under this section, an individual must make application therefor in such manner as the Secretary shall by regulation prescribe and must—

"(1) be enrolled or accepted for enrollment in a full-time course of study at a school of medicine, osteopathy, or dentistry leading to a degree of doctor of medicine, osteopathy, or dentistry or an equivalent degree, and

"(2) enter into an agreement with the Secretary to serve upon completion of his professional training as a commissioned officer of the Regular Corps for a period

of six months for each academic year a scholarship grant is received under this section.

Service under an agreement described in paragraph (2) shall begin within such reasonable period of time after completion of professional training as the Secretary shall by regulation prescribe.

"(c) A scholarship grant under this section shall be made in such uniform amount (not in excess of $3,500 per student per academic year), and shall be paid in such manner, as the Secretary shall by regulation prescribe.

"(d) If an individual fails to comply with the terms of his agreement with the Secretary for service in the Regular Corps, the United States may recover from such individual all or such portion of the amount of scholarship grants received by such individual under this section as the Secretary determines is appropriate. The Secretary shall by regulation provide for the waiver or suspension of any obligation under such an agreement applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to him and if enforcement of such obligation with respect to him would be against equity and good conscience.

"(e) The Secretary may enter into agreements with schools of medicine, osteopathy, or dentistry or other appropriate public or nonprofit private agencies under which such

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schools or other agencies will, as agents of the Secretary, perform such functions in the administration of this section, as the Secretary may specify. Any such agreement with any school or other agency may provide for payment by the Secretary of amounts equal to the expenses actually and necessarily incurred by such school or other agency in carrying out such agreement.

"(f) For the purpose of making scholarship grants under this section, there are authorized to be appropriated $2,000,000 for the fiscal year ending June 30, 1973, $3,000,000 for the fiscal year ending June 30, 1974, and $3,000,000 for the fiscal year ending June 30, 1975. For the fiscal year ending June 30, 1976, and for each succeeding fiscal year, there are authorized to be appropriated such sums as may be necessary to continue to make such grants to students who received such a grant before July 1, 1975, and who are eligible for such a grant under this section during such succeeding fiscal year".

[H.R. 16545, 92d Congress, 2d session, introduced by Mr. Metcalfe on September 6, 1972, and
H.R. 16869, 92d Congress, 2d session, introduced by Mr. Metcalfe (for himself, Mr. Scheuer, Mr. Hechler of West Virginia, Mr. Moss, Mr. Mathis of Georgia, Mr. Nix, Mr. Mitchell, Mr. Dellums, Mr. Conyers, Mrs. Heckler of Massachusetts, Mr. Matsunaga, Mr. Hawkins, Mr. Helstoski, Mrs. Abzug, and Mr. Stokes) on September 27, 1972,

are identical as follows:]

A BILL

To amend the Public Health Service Act to improve the program of medical assistance to areas with health manpower shortages, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. This Act may be cited as the "Emergency Health Personnel Act Amendments of 1972".

SEC. 2. (a) Section 329 (a) of the Public Health Service Act is amended to read as follows:

"SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this section referred to as the 'Corps') which shall consist of those officers of the Regular and Reserve Corps of the Service and such other personnel as the Secretary may desig-

nate and which shall be utilized by the Secretary to improve the delivery of health care and services to persons residing in areas which have critical health manpower shortages."

(b) Section 329 (b) of such Act is amended to read as follows:

"(b) (1) The Secretary shall (A) designate those areas which he determines have critical health manpower shortages, (B) provide assistance to persons seeking assignment of Corps personnel to such designated areas to provide, under this section, health care and services for persons residing in such areas, and (C) conduct such information programs iin such designated areas as may be necessary to inform the public and private health entities serving those areas of the assistance available under this section. The fact that an area is an urban or rural area shall not be considered by the Secretary in determining under clause (A) whether such area has a critical health manpower shortage.

(2) (A) Upon request of a State or local health agency, or any public or nonprofit private health entity in an area designated by the Secretary under paragraph (1) (A), any by the local government for that area, that such health personnel are needed for that area, the Secretary may assign personnel of the corps to provide, under regulations prescribed by the Secretary, health care and services

for all persons residing in such areas. Corps personnel shall be assigned to such area on the basis of the extent of the need for health services within the area and without regard to the ability of the residents of the area to pay for health services.

"(B) In providing health care and services under this section, Corps personnel shall utilize the facilities and organizational forms adapted to the particular needs of the area, shall make services available to all persons in such area regardless of the ability of such persons to pay for the care and services, and regardless of the race, color, religion, or national origin of such persons, and shall provide such services in connection with—

"(i) direct health care programs carried out by the Service;

"(ii) any direct health care programs carried out in whole or in part with Federal financial assistance; or

"(iii) any other health care activity which is in furtherance of the purposes of this section.

"(C) Any person who receives health care or services provided under this section shall be charged for such care or service at a rate established by the Secretary, pursuant to regulations, to recover the reasonable cost of providing such care or service; except that if such person is determined

under regulations of the Secretary to be unable to pay such charge the Secretary shall provide for the furnishing of such care or service at a reduced rate or without charge. If a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of the care or service provided under this section if such care or service had not been provided under this section, the Secretary shall collect from such agency or third party the portion of such cost for which it would be so responsible. Any funds collected by the Secretary under this subparagraph shall be deposited in the Treasury as miscellaneous receipts."

(c) Section 329(c) of such Act is amended by striking out "Service" and inserting in lieu thereof "Corps".

(d) Section 329(d) of such Act is amended—

(1) by striking out "Service" in the first sentence and inserting in lieu thereof "Corps", and by inserting before the period at the end of such sentence the following: ", except that if such area is being served (as determined under regulations of the Secretary) by a hospital or other health care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make to insure the availability of care or services by Corps personnel in the area, arrange for the utilization of such hospital or facility by Corps

personnel in providing care and services in such area, but only if such utilization shall assure the continual provision of care to persons entitled to care and treatment at such facilities at such time.";

(2) by striking out "If there are no such facilities in such area" in the second sentence and inserting in lieu thereof "If there are no health facilities in or serving such area";

(3) by adding after the second sentence the following new sentence: "In providing such care and services, the Secretary may (A) make such arrangements to provide equipment and supplies to those communities that cannot afford to purchase or lease such equipment or supplies, (B) after termination of Corps activities, the above equipment and supplies shall be rendered to the community organization, (C) secure the temporary services of nurses and allied health professionals,"; and

(4) by inserting "(1)" after "(d)" and by adding at the end the following:

"(2) The Secretary shall conduct at medical and nursing schools and other schools of the health professions and training centers for the allied health professions, recruiting programs for the Corps. Such programs shall include the wide dissemination of written information on the Corps and visits to such schools by personnel of the Corps."

(e) Section 329 (e) (1) of such Act is amended by adding at the end thereof the following new sentence: "The Secretary may not assign personnel of the Corps under subsection (b) (2) without the approval of the Council."

(f) Section 329 (f) of such Act is amended (1) by striking out "Service" in paragraphs (1) and (3) and inserting in lieu thereof "Corps", and (2) by striking out "to select commissioned officers of the Service and other personnel" in paragraph (2) and inserting in lieu thereof "to select personnel of the Corps".

(g) Subsection (g) of section 329 of such Act is redesignated as subsection (h) and the following new subsection is inserted after subsection (f) of such section:

"(g) The Secretary shall report to Congress no later than May 15 of each year—

"(1) the number of areas designated under subsection (b) in the calendar year preceding the year in which the report is made as having critical health manpower shortages and the number of areas which the Secretary estimates will be so designated in the calendar year in which the report is made;

"(2) the number and types of Corps personnel assigned in such preceding calendar year to areas designated under subsection (b), the number and types of additional Corps personnel which the Secretary esti-

mates will be assigned to such areas in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps; and

"(3) the number of applications filed in such preceding calendar year for assignment of Corps personnel under this section and the action taken on each such application."

(h) Section 329 (g) of such Act is amended by striking out "and" after "1972;" and by striking out the period at the end and inserting in lieu thereof "; $30,000,000 for the fiscal year ending June 30, 1974; $40,000,000 for the fiscal year ending June 30, 1975."

SEC. 3. (a) The Secretary may not close or transfer control of a hospital or other health care delivery facility of the Public Health Service unless—

(1) he transmits to each House of Congress, on the same day and while each House is in session, a detailed explanation (meeting the requirements of subsection (b)) for the proposed closing or transfer, and

(2) a period of ninety calendar days of continuous session of Congress has elapsed after the date on which such explanation is transmitted.

For purposes of paragraph (2), continuity of session is broken only by an adjournment of Congress sine die, and the days on which either House is not in session because an

adjournment of more than three days to a day certain are excluded in the computation of the ninety-day period.

(b) Each explanation submitted under subsection (a) for closing or transferring control of a hospital or other health care delivery facility of the Public Health Service shall contain—

(1) (A) assurances that persons entitled to treatment and care at the hospital or other facility proposed to be closed or transferred and persons for whom care and treatment at such hospital or other facility is authorized will, after the proposed closing or transfer, continue to be provided such equivalent care and treatment through such hospital or other facility, or under such new arrangement and (B) an estimate of the cost of providing such care and treatment to such persons after the proposed closing or transfer;

(2) (A) assurances that the health service needs of the critical manpower shortage areas near the facility will not be impaired by the closing or transfer and (B) a detailed explanation of how such persons will be provided such care and treatment after the proposed closing or transfer;

(3) (A) assurances that any teaching program conducted at the hospital or other facility proposed to be closed may be conducted at other appropriate facilities,

and (B) a detailed explanation of how such program will be conducted after the proposed closing or transfer; and

(4) the approval of those agencies established under section 314 (a) and (b) of this Act, having jurisdiction in the area in which such hospital or other facility is located, where both such agencies exist or the approval of only one such agency where only one exists in such area.

SEC. 4. Section 741 (f) of the Public Health Service Act is amended (1) by striking out "The payments" in paragraph (2) and inserting in lieu thereof "Except as otherwise provided in this paragraph, the payments", and (2) by adding after and below subparagraph (C) the following:

"In the case of any individual who qualified under paragraph (1) for payments on the principal of and interest on a loan and who, as a member of the National Health Service Corps, practices his profession in an area designated under section 329 (b), the portion of the principal of and interest on the loans for which payments may be made for and on his behalf under paragraph (1) shall, upon completion of the first year of such practice, be 50 per centum and, upon completion of the second year of such practice, be the remaining 50 per centum."

SEC. 5. Title II of the Public Health Service Act is amended by redesignating section 223 of that title entitled "DEFENSE OF CERTAIN MALPRACTICE AND NEGLIGENCE SUITS" as section 224 and by adding after that section the following new section:

"SCHOLARSHIPS

"SEC. 225. (a) To encourage students at schools of medicine, osteopathy, and dentistry to become commissioned officers of the National Health Service Corps upon completion of their professional training, the Secretary may make in accordance with this section scholarship grants for study at such schools.

"(b) To qualify for a scholarship grant under this section, an individual must make application therefor in such manner as the Secretary shall by regulation prescribe and must—

"(1) be enrolled or accepted for enrollment in a full-time course of study at a school of medicine, osteopathy, or dentistry leading to a degree of doctor of medicine, osteopathy, or dentistry or an equivalent degree, and

"(2) enter into an agreement with the Secretary to serve upon completion of his professional training as a commissioned officer of the National Health Service

Corps for a period of six months for each academic year a scholarship grant is received under this section. Service under an agreement described in paragraph (2) shall begin within such reasonable period of time after completion of professional training as the Secretary shall by regulation prescribe. To the extent feasible, the Secretary shall not utilize in administrative duties individuals who are serving in the National Health Service Corps under such agreements.

"(c) A scholarship grant under this section shall be made in such uniform amount (not in excess of $5,000 per student per academic year), and shall be paid in such manner, as the Secretary shall by regulation prescribe.

"(d) If an individual fails to comply with the terms of his agreement with the Secretary for service in the National Health Service Corps, the United States may recover from such individual all or such portion of the amount of scholarship grants received by such individual under this section as the Secretary determines is appropriate. The Secretary shall by regulation provide for the waiver or suspension of any obligation under such an agreement applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to him and if en-

forcement of such obligation with respect to him would be against equity and good conscience.

"(e) The Secretary may enter into agreements with schools of medicine, osteopathy, or dentistry or other appropriate public or nonprofit private agencies under which such schools or other agencies will, as agents of the Secretary, perform such functions in the administration of this section, as the Secretary may specify. Any such agreement with any school or other agency may provide for payment by the Secretary of amounts equal to the expenses actually and necessarily incurred by such school or other agency in carrying out such agreement.

"(f) For the purpose of making scholarship grants under this section, there are authorized to be appropriated $4,000,000 for the fiscal year ending June 30, 1973; $10,800,000 for the fiscal year ending June 30, 1974; and $11,500,000 for the fiscal year ending June 30, 1975. For the fiscal year ending June 30, 1976, and for each succeeding fiscal year, there are authorized to be appropriated such sums as may be necessary to continue to make such grants to students who received such a grant before July 1, 1975, and who are eligible for such a grant under this section during such succeeding fiscal year."

92D CONGRESS
2D SESSION

S. 3858

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 5, 1972
Referred to the Committee on Interstate and Foreign Commerce

AN ACT

To amend the Public Health Service Act to improve the program of medical assistance to areas with health manpower shortages, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Emergency Health Personnel Act Amendments of 1972".

SEC. 2. (a) Section 329 (a) of the Public Health Service Act is amended to read as follows:

"SEC. 329. (a) There is established, within the Service, the National Health Service Corps (hereinafter in this section referred to as the 'Corps') which shall consist of those officers of the Regular and Reserve Corps of the Serv-

ice and such other personnel as the Secretary may designate and which shall be utilized by the Secretary to improve the delivery of health care and services to persons residing in areas which have critical health manpower shortages."

(b) Section 329 (b) of such Act is amended to read as follows:

"(b) (1) The Secretary shall (A) designate those areas which he determines have critical health manpower shortages, (B) conduct information programs in such areas as may be necessary to inform the public and private health entities serving those areas of the benefits available under this Act and to encourage their application for such benefits, and (C) assist such entities to apply for the assignment of Corps personnel and other benefits authorized under this Act.

"(2) (A) Upon request of a State or local health agency, or any public or nonprofit private health entity in an area designated by the Secretary under paragraph (1) (A), and upon certification to the Secretary by the State and the district medical societies (or dental societies, or other appropriate health societies as the case may be) for that area, and by the local government for that area, that such health personnel are needed for that area, the Secretary may assign personnel of the Corps to provide, under regulations prescribed by the Secretary, health care and services

for all persons residing in such areas except that where all of the foregoing conditions are met in an area, except certification of need by the State and local medical, dental, or other health societies, and the Secretary finds from all the facts presented that such certification has clearly been arbitrarily and capriciously withheld, then the Secretary may, after consultation with the appropriate medical, dental, or other health societies, assign such personnel to that area. Corps personnel shall be assigned to such area on the basis of the extent of the need for health services within the area and without regard to the ability of the residents of the area to pay for health services.

"(B) In providing health care and services under this section, Corps personnel shall utilize the facilities and organizational forms adapted to the particular needs of the area and shall make services equally available to all persons in such area regardless of the ability of such person to pay for the care and services provided in connection with—

"(i) direct health care programs carried out by the Service;

"(ii) any direct health care programs carried out in whole or in part with Federal financial assistance; or

"(iii) any other health care activity which is in furtherance of the purposes of this section.

"(C) Any person who receives health care or services

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provided under this section shall be charged for such care or service at a rate and in a manner (including prepayment, capitation, incentive reimbursement, fee-for-service, or other basis) established by the Secretary, pursuant to regulations, to recover the reasonable cost of providing such care or service; except that if such person is determined under regulations of the Secretary to be unable to pay such charge the Secretary shall provide for the furnishing of such care or service at a reduced rate or without charge. If a Federal agency, an agency of a State or local government, or other third party would be responsible for all or part of the cost of the care or service provided under this section if such care or service had not been provided under this section, the Secretary shall collect on a capitation, prepayment, incentive reimbursement, fee-for-service, or other basis from such agency or third party the portion of such cost for which it would be so responsible. Any funds collected by the Secretary under this subparagraph shall be deposited in the Treasury as miscellaneous receipts and funds allocated or obligated under this section shall not be dependent on or related to such fees collected in any way.

"(D) Notwithstanding the provisions of the Federal Property and Administrative Services Act (40 U.S.C. 471), the Secretary may transfer the title to any or all facilities, equipment, and supplies, belonging to the Service and being

utilized by the Corps in a medically underserved area designated by the Secretary under subsection (a) to any public or private nonprofit institution which the Secretary determines will conform to minimum standards of operation prescribed by him. In a case where the Secretary determines, after a hearing on the record, that such real or personal property is not being utilized in conformance with such minimum standards, title shall revert (after payment of proper compensation for facility improvements, if any) to the United States. This paragraph shall not apply to any hospital or clinical facilities operated by the Service prior to December 31, 1971."

(c) Section 329 (c) of such Act is amended by striking out "Service" and inserting in lieu thereof "Corps".

(d) Section 329 (d) of such Act is amended—

(1) by striking out "Service" in the first sentence and inserting in lieu thereof "Corps", and by inserting before the period at the end of such sentence the following: ", except that if such area is being served (as determined under regulations of the Secretary) by a hospital or other health care delivery facility of the Service, the Secretary shall, in addition to such other arrangements as the Secretary may make to insure the availability of care or services by Corps personnel in the area, arrange for the utilization of such hospital or facility by Corps

personnel in providing care and services in such area, but only if such utilization shall assure the continual provision of care to persons entitled to care and treatment at such facilities at such time.";

(2) by striking out "If there are no such facilities in such area" in the second sentence and inserting in lieu thereof "If there are no health facilities in or serving such area";

(3) by adding after the second sentence the following new sentence: "In providing such care and services, the Secretary may (A) make such arrangements as he determines are necessary for the use of equipment and supplies of the Service and for the lease or acquisition of equipment and supplies, and (B) secure the temporary services of nurses and allied health professionals."; and

(4) by inserting "(1)" after "(d)" and by adding at the end the following:

"(2) The Secretary shall conduct at medical and nursing schools and other schools of the health professions and training centers for the allied health professions, recruiting programs for the Corps. Such programs shall include the wide dissemination of written information on the Corps and visits to such schools by personnel of the Corps.

"(3) (A) For the purpose of recruiting persons for the Corps who have gained experience in the provision of health

services as a direct result of specialized military training, the Secretary, in cooperation with the Department of Defense and the Veterans Administration shall develop a list of persons having such experience.

"(B) In the assignment of personnel to designated health manpower shortage areas, the Secretary shall give priority to persons recruited from the list developed under paragraph (A), with respect to such individuals' desires.".

(e) Section 329(f) of such Act is amended (1) by striking out "Service" in paragraphs (1) and (3) and inserting in lieu thereof "Corps", and (2) by striking out "to select commissioned officers of the Service and other personnel" in paragraph (2) and inserting in lieu thereof "to select personnel of the Corps".

(f) Subsection (g) of section 329 of such Act is redesignated as subsection (k) and the following new subsections are inserted after subsection (f) of such section:

"(g) The Secretary shall report to Congress no later than May 15 of each year—

"(1) the number of areas designated under subsection (b) in the calendar year preceding the year in which the report is made as having critical health manpower shortages and the number of areas which the Secretary estimates will be so designated in the calendar year in which the report is made;

"(2) the number and types of Corps personnel assigned in such preceding calendar year to areas designated under subsection (b), the number and types of additional Corps personnel which the Secretary estimates will be assigned to such areas in the calendar year in which the report is submitted, and the need (if any) for additional personnel for the Corps; and

"(3) the number of applications filed in such preceding calendar year for assignment of Corps personnel under this section and the action taken on each such application."

"(h) Section 5532 of title 5, United States Code shall not apply to a retired officer of a regular component of a uniformed service who holds a full-time position with the Corps, during the time he holds such position.

"(i) The Secretary may from time to time and for such period as he deems advisable, secure the assistance and advice of experts, scholars, and consultants, including the services of advertising and other public information specialists, to foster, promote, and improve the image of the Corps with regard to the provision of health services and with the further aim of emphasizing recruitment of new and retention of present members of the Corps.

"(j) The Secretary may reimburse applicants for positions in the Corps for actual expenses incurred in traveling

to and from their place of residence to an area in which they would be assigned for the purpose of evaluating such area with regard to being assigned in such area. The Secretary shall not reimburse an applicant for more than one such trip."

(g) Section 329 (k) as redesignated by this Act, of such Act is amended by striking out "and" after "1972;" and by striking out the period at the end and inserting in lieu thereof "; $30,000,000 for the fiscal year ending June 30, 1974; $40,000,000 for the fiscal year ending June 30, 1975, sums appropriated under this section shall remain available until expended."

(h) Section 329 of such Act is further amended by adding at the end thereof the following new subsection:

"(l) Where the Corps requires personnel assigned to designated shortage areas to obtain State and local licenses or permits, the Secretary shall pay the fees therefor."

SEC. 3. (a) The Secretary may not close or transfer control of a hospital or other health care delivery facility of the Public Health Service unless—

(1) he transmits to each House of Congress, on the same day and while each House is in session, a detailed explanation (meeting the requirements of subsection (b)) for the proposed closing or transfer, and

(2) a period of ninety calendar days of continuous

session of Congress has elapsed after the date on which such explanation is transmitted.

For purposes of paragraph (2), continuity of session is broken only by an adjournment of Congress sine die, and the days on which either House is not in session because an adjournment of more than three days to a day certain are excluded in the computation of the ninety-day period.

(b) Each explanation submitted under subsection (a) for closing or transferring control of a hospital or other health care delivery facility of the Public Health Service shall contain—

(1) (A) assurances that persons entitled to treatment and care at the hospital or other facility proposed to be closed or transferred and persons for whom care and treatment at such hospital or other facility is authorized will, after the proposed closing or transfer, continue to be provided such equivalent care and treatment through such hospital or other facility, or under such new arrangement and (B) a detailed explanation of how such care will be provided to such persons, and an estimate of the cost of providing such care and treatment to such persons after the proposed closing or transfer;

(2) (A) assurances that the capacity to supply health services to the critical manpower shortage areas near the facility will not be impaired by the closing or

transfer and (B) a detailed explanation of how persons residing in such areas will be provided such care and treatment after the proposed closing or transfer;

(3) (A) assurances that any teaching program conducted at the hospital or other facility proposed to be closed may be conducted at other appropriate facilities, and (B) a detailed explanation of how such program will be conducted after the proposed closing or transfer; and

(4) the approval of those agencies established under section 314 (a) and (b) of the Public Health Service Act, having jurisdiction in the area in which such hospital or other facility is located, where both such agencies exist or the approval of only one such agency where only one exists in such area.

SEC. 4. Section 741 (f) of the Public Health Service Act is amended (1) by striking out "The payments" in paragraph (2) and inserting in lieu thereof "Except as otherwise provided in this paragraph, the payments", and (2) by adding after and below subparagraph (C) the following:

"In the case of any individual who qualified under paragraph (1) for payments on the principal of and interest on a loan and who, as a member of the National Health Service Corps, practices his profession in an area designated under

section 329(b), the portion of the principal of and interest on the loans for which payments may be made for and on his behalf under paragraph (1) shall, upon completion of the first year of such practice, be 50 per centum and, upon completion of the second year of such practice, be the remaining 50 per centum."

SEC. 5. Section 218 of the Public Health Service Act is amended to read as follows:

"PUBLIC HEALTH AND NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP TRAINING PROGRAM

"SEC. 218. (a) The purpose of the Public Health and National Health Service Corps scholarship training program (hereinafter referred to as 'such program') is to obtain trained physicians, dentists, nurses, and other health-related specialists for the National Health Service Corps and the Public Health Service Corps of the Department of Health, Education, and Welfare.

"(b) To be eligible for acceptance and continued participation in such program, each applicant must—

"(1) be accepted for enrollment, or be enrolled as a full-time student in an accredited (as determined by the Secretary) educational institution in the United States, or its terriories or possessions;

"(2) pursue an approved course of study, and

maintain an acceptable level of academic standing, leading to a degree in medicine, dentistry, or other health related specialty, as determined by the Secretary;

"(3) be eligible for, or hold an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or be selected for civilian service in the National Health Service Corps; and

"(4) agree in writing to serve in the Commissioned Corps of the Public Health Service or as a civilian member of the National Health Service Corps following completion of training as provided in subsection (f) of this section, in the National Health Service Corps, the Indian Health Service, the Federal Health Programs Service, and such other programs as the Secretary may designate.

"(c) Each participant in such program will be authorized a stipend for each approved academic year of training, not to exceed four years, in an amount prescribed by the Secretary and payable in monthly installments. The stipend shall not exceed an amount equal to the basic pay and allowances of a commissioned officer on active duty in pay grade O–1 with less than two years of service, plus an amount to cover the reasonable cost of books, supplies, equipment, student medical expenses, and other necessary educational expenses which are not otherwise paid as a part of the basic tuition payment.

"(d) The Secretary may contract with an accredited educational institution for the payment of tuition and other education expenses, not otherwise covered under subsection (c) of this section, for persons participating in such program. If necessary, persons participating in such program may be reimbursed for the actual cost of tuition and other educational expenses authorized in this subsection, in lieu of a contract with the educational institution.

"(e) A person participating in such program shall be obligated to serve on active duty as a commissioned officer in the Public Health Service or as a civilian member of the National Health Service Corps following completion of academic training, for a period of time prescribed by the Secretary which will not be less than one year of service on active duty for each academic year of training received under such program. For persons receiving a degree from a school of medicine, osteopathy or dentistry, the commencement of a period of obligated service can be deferred for the period of time required to complete internship and residency training. For persons receiving degrees in other health professions the obligated service period will commence upon completion of their academic training. Periods of internship or residency shall not be creditable in satisfying an active duty service obligation under this section except that if such residency is served in a Public Health Service facility or facility of the

National Health Service Corps such residency shall be counted as satisfying the active duty service obligation under this section.

"(f) If, for any reasons, a person fails to complete an active duty service obligation under this section, he shall be liable for the payment of an amount equal to the cost of tuition, and other education expenses, and salary expenses, paid under this section plus interest at the maximum legal prevailing rate. Any amount which the United States is entitled to recover under this paragraph shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount, be paid to the United States. Until any amount due the United States under this paragraph on account of any grant under this subpart is paid, there shall accrue to the United States interest on such amount at the same rate as that fixed by the Secretary of the Treasury with respect to the grant on account of which such amount is due the United States.

"(g) When a person undergoing training in such program is academically dismissed or voluntarily terminates academic training, he shall be liable for repayment to the Government for an amount equal to the cost of tuition and other educational expenses paid from Federal funds, plus all salary payment which he received under such program.

"(h) The Secretary shall by regulations provide for the

waiver or suspension of any such obligation applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.

"(i) Notwithstanding any other provision of law, persons undergoing academic training under such program shall not be counted against any employment ceiling affecting the Department of Health, Education, and Welfare.

"(j) The Secretary of Health, Education, and Welfare shall issue regulations governing the implementation of this section.

"(k) To carry out the purposes of this program, there are authorized to be appropriated $10,800,000 for the fiscal year ending June 30, 1974, and $11,500,000 for the fiscal year ending June 30, 1975."

SEC. 6. Section 2(f) of the Public Health Service Act is amended by inserting after "Puerto Rico," the following: "Guam, American Samoa, and the Trust Territory of the Pacific Islands,".

Passed the Senate August 18, 1972.

Attest: FRANCIS R. VALEO,

Secretary.

DEPARTMENT OF DEFENSE,
OFFICE OF THE GENERAL COUNSEL,
Washington, D.C., September 28, 1972.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of the Department of Defense on S. 3858, 92nd Congress, an Act "To amend the Public Health Service Act to improve the program of medical assistance to areas with health manpower shortages, and for other purposes."

The purpose of the bill is stated in its title.

Inasmuch as the bill would be administered by the Department of Health, Education and Welfare, the Department of Defense defers to that Department as to its merits.

The Office of Management and Budget advises that, from the standpoint of the Administration's program, there is no objection to the presentation of this report for the consideration of the Committee.

Sincerely,

J. FRED BUZHARDT,
General Counsel.

Mr. ROGERS. Our first witness this afternoon is our distinguished colleague, who is a member of the full committee, and has taken an extreme interest in health matters and has been most helpful to this committee and its deliberations on other health matters, particularly in this legislation. The committee welcomes our colleague, the Honorable Ralph Metcalfe.

STATEMENT OF HON. RALPH H. METCALFE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. METCALFE. Mr. Chairman and distinguished members of this subcommittee, it is a pleasure for me to be here this afternoon. I happen to believe that this committee is one of the finest here in Congress, and certainly, it is one of the hardest working bodies. Of course, this condition is no accident. Anyone familiar with Chairman Paul Rogers knows that he is the inspiration and the backbone of this committee. Perhaps his secret is that he will listen to everyone's point of view and where there is cause, will immediately lend his support. I know, because this is the way he has reacted to some of my suggestions, and consequently, I have made a marginal impact upon national health legislation.

I am also aware of the qualifications and the concerted effort of the others on this committee. Everyone recognizes that this committee is a close-knit unit, and each member contributes to the common goals. However, my distinguished colleague, Congressman William Roy, has had a great impact upon legislation by his work in the area of health legislation and especially on the health maintenance organization bill. Congressman Tim Carter, another distinguished medical doctor, is well known for the medical perspective and dedication he brings to the work of the subcommittee.

This afternoon, we have before us a measure which would extend the Emergency Health Personnel Act of 1970. Though it is a relatively small program in terms of scope and budget outlay, it does have considerable potential for alleviating some of the Nation's more critical health care needs. I'm sure that this committee was hoping to be able to review the performance of this program at this time, but of course,

we do not yet have a significant number of National Health Service Corps personnel in these critical areas to make an assessment.

I would like to see this program extended and hope that the final bill contains some of the changes set forth in my bill, H.R. 16545. The concept and the approach manifested in the 1970 act are certainly worthy of our interest. The House report of December 3, 1970 (92–1662) stated that the—

> principal purpose of the Bill is to provide for the use of commissioned officers of the Public Health Service to provide health services to persons living in communities and areas of the United States where health personnel and services are inadequate.

The congressional intent is very clear on this point and the record shows that then, as well as now, there are some critical health needs which this act was supposed to alleviate. For example, Senator Stevens from Alaska in testifying on Senate bill 3858, said:

> To illustrate this real need for more health care in the United States, there are 132 counties in this country which have no physicians and 225 counties with no dentists.

He indicated further, that there are approximately 5,000 communities without any health care services. Given this state of affairs it seems reasonable that the Secretary of Health, Education, and Welfare and the Director of the National Health Service Corps could have done much more than they have in instituting this program. After all, the first appropriation of $3 million was available for fiscal year 1971. Subsequent to that, there was $12.5 million appropriation for fiscal year 1972. The blame certainly cannot be laid upon the Congress.

The bill that I introduced with 14 cosponsors attempts to eliminate some of the more obvious problems confronting this program. According to the Senate report (92–1062), as of July 26, the State and local medical and dental societies have refused or delayed certification of the need of some 17 physicians and 16 dentists. This is most unfortunate in view of the urgent need of the potentially thousands of patients who could be served by these doctors. H.R. 16545, would simply take away this arbitrary power of the State and local medical societies. Indeed, they have an inordinate say about the health services of States and other localities. This is obvious, because the medical providers and professions are well represented on the planning agencies created by the Public Health Service Act under sections 314(a) and (b). These agencies have to also give their personal approval before Corps personnel can be assigned. It seems to me that the powerful medical societies do not need two chances to divert the will of the local citizenry. My bill would provide a more powerful voice to the people of the community.

In reviewing the areas which have been designated by the Secretary to receive Corps personnel, I see that there is an 80- to 20-percent disparity between rural and urban areas. I think that there is a critical health need in both rural and urban areas and my bill would correct this imbalance.

That completes my written remarks and I will try to answer any questions you may have at this time.

Mr. Chairman, I have here a report by Mr. Frederick T. Merrill, Jr., of the Democratic Study Group, which is entitled: "Health Crisis,"

and I ask permission at this time that this report become a part of the record.

Mr. Rogers. Without objection, the report will be made a part of the record at this point.

(The Democratic Study Group report entitled: "The Health Crisis" follows:)

The Health Crisis

(DEMOCRATIC STUDY GROUP, 1972 ISSUE REPORT NO. 9—SEPTEMBER 25, 1972)

The health issue is at the fore as a matter of public concern. The American people are aware that they are not receiving the kind of health care that the citizens of the richest nation on earth should expect. President Nixon himself on two occasions—July of 1969 and February of 1971—spoke of a "massive crisis" in our health care system. The crisis continues today, fueled by lack of Administration leadership in the health field and Presidential vetoes of health bills and fund reductions in vital programs.

In response to the demand for better health care at reasonable cost, Democrats in the Congress are backing the Kennedy-Griffiths Health Security Program, which calls for comprehensive overhaul of our health care system. The Administration and Congressional Republicans are supporting less comprehensive legislation based on the existing structure.

This DSG Issue Report contains the following sections:

I. Background;
II. The Problem;
III. The Record, 1969–1972;
IV. National Health Insurance;
V. GOP Line and Rebuttal;
VI. Key House Votes;
VII. Source Material.

Section I

BACKGROUND

Health care in the United States has long been the domain of the medical profession, operating in concert with hospital bureaucracies and the purveyors of private health insurance. This "health industry" his successfully thwarted development of a coordinated federal program for disbursing funds, not to mention a national health policy to guarantee adequate health care for all Americans.

Prior to the enactment of Medicare and Medicaid in the mid-1960s, the federal role in the health field was confined to regulation of drugs and other medical paraphernalia (Pure Food and Drug Act of 1906), the disbursing of funds under formula grants for hospital construction and modernization (Hill-Burton Act of 1946), and, more recently, federal funding for a variety of medical education and research programs. Attempts during the 1950s to provide assistance for private hospital insurance programs and state programs for elderly sick persons were stymied by the American Medical Association (AMA).

The AMA was unable to stop the enactment of Medicare (federal assistance to elderly sick persons) and Medicaid (federal grants to states for poor sick persons) in the mid-1960s, so it concentrated on insuring that these programs would be run by the medical profession primarily for its own benefit. Language inserted in the legislation at the insistence of the AMA prohibits the government from exercising control over the billions of tax dollars that flow under the program into hospital coffers and doctors' pockets. As a result, costs of the program have soared to an estimated $14 BILLION this year, forcing a 45% rise in the monthly Medicare premium from $4 in 1968 to $5.80 this year, and state cutbacks in Medicaid eligibility. This cost-push inflation is fueled by a payment system that reimburses doctors on the basis of their "usual and customary" fees and hospitals on the basis of what amounts to a cost-plus formula.

Most of our existing basic public health legislation was proposed by the Kennedy and Johnson Administrations and enacted by the Congress during the 1960s. Laws were passed authorizing substantial amounts for construction of mental health facilities, medical schools, and schools of public health. Funds for the first time became available to establish regional medical programs for heart, cancer, and stroke research, programs to vaccinate against communicable diseases, and programs to assist the mentally retarded. The landmark Compre-

hensive Health Planning and Services Act was passed in 1966, followed by the Health Manpower Act in 1968. These health programs all received overwhelming bi-partisan support in the Congress.

Over the three and a half years of the Nixon Administration, these Health Services and Mental Health Administration (HSMHA) and National Institutes of Health (NIH) public health programs have been extended and perfected by the Congress, but Administration funding requests have consistently fallen far below Congressional authorizations. In fact, for FY 1973 the budget estimate of $4.16 BILLION even fell below the comparable $4.27 BILLION appropriation for FY 1972. Yet the nation depends on these programs for improvement of health services and development of health resources.

While federal public health programs and Medicare/Medicaid have made significant contributions in research and increasing the accessibility of health care, our health care delivery systems are on the point of breakdown. Runaway inflation of medical costs and porous health insurance programs mean that tens of millions of Americans receive inadequate health care. The wastefulness of the delivery system is largely the responsibility of the medical profession itself, which created it and which runs it.

Financing health care and delivering it to the consumer depend on organization of resources, personnel, and facilities. Yet no such organization currently exists. The Assistant Secretary of HEW, in theory the nation's top health officer and a logical focal point for organizing our resources, controls only about 20% of the federal health budget and has little authority over the more than 25 departments and agencies that administer health programs. In the private sector, disorganization and inefficiency are the rule, with over one thousand entities offering competing health insurance plans and the medical profession fighting to preserve itself as a cottage industry.

The continuing crisis in our health care has resulted in widespread demand for national health insurance. Democrats in the Congress, supported by the more progressive elements of the medical profession and by organized labor, have developed the Health Security Program to provide comprehensive medical care for every American at an affordable cost. The Nixon Administration, supported by the health insurors and the traditional medical community, has countered with proposals to provide coverage and financing through the private medical insurance industry. While Congress, the government, and the health industry debate the cure, the crisis worsens at the expense of the health of the American people.

Section II

THE PROBLEM

The health care crisis in the United States is worsening. Despite public and private national health expenditures of $75 billion a year—7% of the GNP and more than any other nation—Americans receive poorer care and die sooner than the citizens of most of the other industrialized countries of the world. The United States ranks:

14th in infant mortality. If we had the same rate as Sweden, 40,000 fewer American babies would have died last year;

11th in maternal mortality. In 1952, the U.S. had the lowest rate of maternal mortality of any country in the world;

22nd in life expectancy for men, 18 of the 25 countries in Western and Eastern Europe have lower male mortality rates;

7th in life expectancy for women. Women in Holland can expect to live two years longer than American women;

16th in the death rate for middle-aged men. Since 1900 life expectancy in the U.S. has risen 21 years, but only 3 years for men over 45; and

8th in doctors per population (the Soviet Union has twice as many doctors as the U.S.). Moreover, our doctor population is maldistributed in terms of national health needs.

These overall statistics do not tell the entire story. Infant mortality among non-whites is almost double the rate for whites (35.9 v. 19.7 per 1,000 births). Persons in the lowest income category are four times more likely to have an activity-limiting chronic condition as those earning over $10,000 per year. The poor average 50% more disability days per year than the non-poor. In short, the poor get sicker and the sick get poorer.

Following are the key components of the crisis in health care in the United States:

Costs of medical care

Americans spend 150% more for health care than they did a decade ago ($324 v. $145 per year); over this period the Consumer Price Index as a whole rose by less than 33%. Over the past four years, health costs have jumped 30%, compared to 21% for the CPI. And in the past year, health costs have gone up 12.9%—triple the 4.3% jump in the CPI.

The two fastest-rising medical care prices are hospital charges and doctor's fees. Over the past decade, hospital charges have tripled. In 1970 the average daily cost per patient in community hospitals was $80; today, hospital charges in metropolitan areas are hovering around $100 with intensive care charges nearing $500. Since 1966, doctor's fees have gone up 40%, more than double the cost-of-living rise—and private funds must pay for three-fourths of doctor's fees.

Shortages of health personnel

The U.S. Public Health Service estimates that the country currently faces health personnel shortages approaching 500,000. We need 50,000 more doctors, 20,000 more dentists, 150,000 more nurses, over 100,000 environmental health specialists, and 150,000 health professionals. By 1980, this health person-mostly from underdeveloped countries that need them even more than we do, still 11,000 hospital residencies are unfilled.

Inequitable distribution of health resources

Because of migration of doctors to the suburbs, doctor shortages are most acute in the areas of greatest need—the center cities and remote rural areas. 40 million Americans never see a doctor under any circumstances, and millions of others do so only after being struck by serious illness. Medical facilities in urban areas are starved for modernization funds—with a current backlog of over $10 BILLION in needs—but construction funds for new facilities continue to flow to areas of lesser need under outdated formula grants.

Gaps in insurance coverage

In 1969, the last year for which figures are available, 34 million Americans had no hospital insurance. The poor, who need insurance the most, are covered the least—over half of those earning less than $5000 a year are not covered for hospital insurance. Most health insurance plans are tied to the worker's company; job displacements have deprived thousands of families of all coverage.

Aside from basic hospital insurance, a third of all Americans are not covered against in-hospital medical expenses. A majority have no coverage to meet the added costs of long-term illness, such as convalescent care. Overall, insurance plans meet only 37¢ of every consumer dollar spent on health care, with most of the remainder coming out of the consumer's pocket. The percentage of covered expenditures is rising so slowly that it will take until the year 2000 to cover even two-thirds of medical costs.

Abdication of National Health leadership

Until recently, the Public Health Service educated the nation in hygiene, sanitation, medical research, and standard setting for treatment of disease. In the 1960's, Regional Medical Programs (RMP) and Comprehensive Health Planning (CHP) legislation were enacted by the Congress to carry forth this work.

The Public Health Service has atrophied, and the RMP and CHP programs have been hindered as a result of inadequate funding. No federal leadership now exists in such elementary areas as vitamin standards, and proper diet—in fact, federal leadership in cooperative school programs is non-existent.

The Surgeon General has been silenced and rarely speaks on national health issues. The HEW Assistant Secretary for Health and Scientific Affairs doesn't even have charge of the nation's main health programs, Medicare and Medicaid. The system operates in chaos; the absence of a strong federal voice contributes to the problem.

Section III

THE RECORD, 1969–1972

In July of 1969, President Nixon testified to the magnitude of the health crisis at that time:

"We face a massive crisis in this area and, unless action is taken, both administratively and legislatively, to meet that crisis within the next two or three years, we will have a breakdown in our medical care system which would have consequences affecting millions of people throughout this country."

In February of 1971, President Nixon returned once more to the subject of health care in the United States:

"Nineteen months ago I said that America's medical system faced a 'massive crisis.' Since that statement was made that crisis has deepened."

Nineteen months have once again elapsed. Unfortunately the President need only repeat his February 1971 statement to describe the health care situation in September of 1972.

Presidential vetoes

President Nixon has vetoed four major Congressional initiatives to cope with the nation's health crisis. In June of 1970, he vetoed H.R. 11102, the Hill-Burton Medical Facilities Construction and Modernization Amendments of 1969, after it has passed the House unanimously (see Key Vote No. 1). At the end of the 91st Congress, he pocket-vetoed S. 3418, which would have increased the supply of family doctors. The measure had passed the Congress with only two dissenting votes, so the President waited until the Congress recessed for Christmas to avoid an almost certain override.

The President also vetoed the FY 1970 and FY 1973 Labor/HEW Appropriations bills, both of which contained emergency Congressional increases in health appropriations. The President vetoed H.R. 13111, the FY 1970 Labor/HEW Appropriation, in part because it contained $222 million extra for health programs, and on January 28, 1970, 83% of House Republicans joined in sustaining the veto (see Key Vote No. 2).

As part of the price for signing the bill, the President forced a $105 million reduction in health facility construction funds, and an across-the-board 2% reduction in the entire appropriation, which cut into numerous vital health programs. Not content with these cuts, the Administration then backed an unsuccessful last-minute move on February 19, 1970, by 88% of House Republicans to amend the new version of the vetoed bill (H.R. 15931) to give the President discretion to cut another 2.5% in any or all programs (see Key Vote No. 3). The Administration formally opposed even the watered-down version on final passage, but a majority of Republicans finally deserted the ship and the measure passed (see Key Vote No. 4).

When the conference report accompanying H.R. 15417, the FY 1973 Labor/HEW Appropriation reached the House floor August 9, 1972, 77% of House Republicans voted against it because it contained $1.76 BILLION in added funds, $958 million of which were increases for health programs (see Key Vote No. 5). The President made good on his threat to veto the measure, and on August 16, 92% of House Republicans voted to sustain the veto (see Key Vote No. 6).

The President's veto forced $422.8 million in reductions in the funds added by the Congress for programs to help meet the health crisis. The new, post-veto version of the bill (H.R. 16654) passed the House on September 19, 1972 (see Key Vote No. 7) with the following forced reductions in major health programs:

[In millions]

Agency and program	Fiscal year 1973 request	1st version (H.R. 15417)	2d version (H.R. 16654)
National Institutes of Health	$2,192.6	$2,723.7	$2,496.7
National Heart and Lung Institute	255.3	320.0	294.4
Health manpower	533.6	846.4	713.0
Health Services and Mental Health	1,964.4	2,391.2	2,195.3
Mental health	613.8	783.3	727.6
Preventive health services	154.4	209.4	159.9
Health services delivery	751.3	798.0	751.3
Health Services planning and development	330.2	489.6	445.6

Even with these cuts, the President has refused so far to support the bill, which is currently awaiting final Congressional approval.

Inadequate funding requests

The legislative committees of the Congress, primarily the Interstate and Foreign Commerce Committee of the House and the Labor and Public Wel-

fare Committee of the Senate, have jurisdiction over most federal health programs. These committees, after taking expert testimony, have perfected and extended numerous health programs during the 91st and 92nd Congress, and set authorizations based on what experts believe is needed to meet our national health requirements. The Administration has consistently avoided funding the programs at the levels set by Congress by submitting inadequate requests for appropriation in its budget.

The FY 1973 budget recommends total budget authority for federal health programs of $23.68 BILLION, but over five-sixths of this total is allocated to ongoing programs to maintain the *status quo*, and trust fund expenditures such as Medicare. The following table compares Congressional authorizations with Administration requests for FY 1973 for those NIH and HSMHA programs directed toward improvement of heatlh services and the development of health resources:

[In millions]

Agency and program	Authorization[1] or need	Fiscal year 1973 request
National Institutes of Health	$3,264.9	$2,192.6
Cancer Institute	532.2	432.2
Heart and Lung Institute	337.9	255.3
Arthritis and Metabolic Disease Institute	182.2	159.1
Institute of Neurological Disease and Stroke	145.1	117.9
Institute of Allergy and Infectious Disease	129.7	112.6
Institute of General Medical Science	204.7	176.0
Institute of Child Health and Human Development	188.0	127.2
Eye Institute	42.2	37.4
Institute of Environmental Health Sciences	33.2	29.0
Institute of Dental Research	51.2	44.4
Fogarty International Center	4.7	4.5
Biologics Standards	9.7	9.5
Research Resources	100.1	75.0
Medical, dental, and related health professions manpower	795.5	331.6
Dental health	16.5	13.0
Nurse training	243.3	122.9
Public health training	38.6	21.6
Allied health professions training	103.9	35.6
Program direction	8.5	8.9
Other NIH programs	97.7	78.7
Health Services and Mental Health Administration	2,930.1	1,964.4
Mental health	890.9	613.8
Alcoholism & narcotics	(287.5)	(185.5)
Child mental health programs	(30.0)	(10.0)
Community health center staffing	(195.1)	(135.1)
Health services planning and development	812.3	330.2
Regional medical programs	(250.0)	(130.3)
Medical facilities construction and modernization	(423.3)	(90.9)
Health services delivery	939.3	751.3
Comprehensive health services	(323.9)	(249.2)
Maternal and child health	(329.1)	(252.7)
Preventive health services	174.5	157.4
St. Elizabeth's Hospital	30.7	30.7
Other HSMHA programs	82.4	81.1
Total	6,195.0	4,157.0

[1] In instances where Congress has not authorized a specific amount, professional estimate of the coalition on health funding has been used.

The table shows that Administration funding requests are running $2.04 billion below what the authorizing committees of the Congress and health experts believe is needed to deal with the health crisis. Requests for these programs are barely two-thirds of what is needed in this fiscal year. The FY 1970, FY 1971, and FY 1972 Nixon health budgets contained similar inadequate requests for health funds, thereby creating an enormous backlog of unmet health needs.

Congressional fund increases

The Appropriations Committees of the Congress have added funds to the Administration requests in each fiscal year, but Presidential vetoes backed by House Republicans forced reductions in the add-ons in FY 1970 and FY 1973.[1]

[1] The original fiscal year 1970 and fiscal year 1973 add-ons were $222 million and $958 million, respectively, but vetoes forced the lower amounts.

Following are the Committee-added amounts for NIH and HSMHA health appropriations in each fiscal year:

[In millions]

Year	Request	Final appropriation	Difference
Fiscal 1970	$2,432.5	$2,598.8	+$166.3
Fiscal 1971	2,811.9	3,111.2	+299.3
Fiscal 1972	3,147.2	3,676.7	+529.5
Fiscal 1973 (House bill)	4,157.0	4,692.2	+535.2

Thus the Congress has increased actual health appropriations by a total of $1.53 BILLION over the four Nixon budget submissions.

During the 1st session of the 92nd Congress, Congressional Democrats attempted unsuccessfully to increase health appropriations above the committee-approved amounts on the House floor. On July 27, 1971, 79% of House Republicans successfully opposed an effort to add $230 million to H.R. 10061, the FY 1972 Labor HEW Appropriation, for research, construction, communicable disease control, maternal and child care, and other key programs (see Key Vote No. 8).

HMO backtracking

The Administration has backed down on one of its key health proposals, legislation to facilitate establishment of Health Maintenance Organizations (HMOs). HMOs are pre-paid group practices (instead of physicians practicing alone charging fees for services rendered), and would vastly improve preventive care and bring down costs to the consumer. The HMO concept has been strongly endorsed by Congressional health leaders such as Reps. Rogers and Roy and Senator Kennedy, in addition to receiving support from all elements of the health industry except the AMA.

The key stumbling block to establishment of HMOs are state laws which prevent group practice. On February 18, 1971, President Nixon endorsed pre-emption of "archaic laws which prohibit or limit the group practice of medicine," and directed HEW "to develop a model statute which the states themselves can adopt to correct these anomilies." These laws currently give state medical societies a veto over group practices. Under pressure from the AMA, the Administration on August 10, 1972, reversed itself and now opposes pre-emption of such state laws.

The initial White House proposal projected HMO expenditures of $2.1 BILLION over three years, leading ultimately to a national network of 1,210 HMOs serving 90% of the U.S. population by 1980. The Administration is now down to supporting a three-year $335.3 million "experimental" program with federal grants available only for feasibility studies and initial development costs.

The Senate recenty passed a three-year $5.1 BILLION program of federal grants to subsidize establishment and operation of HMOs, with $1.8 BILLION of the total earmarked for health care for the poor who otherwise could not afford HMOs. The AMA, working through Dr. Malcolm Todd at the Committee to Re-elect the President, is mounting a full scale campaign to gut or kill the proposal in the House Interstate and Foreign Commerce Committee, and passage this year is in doubt. Dr. Todd has said that the AMA brought "all the force *we* could" in opposition to HMOs, adding that the pressure had caused "some backtracking on the part of the White House."

Section IV

NATIONAL HEALTH INSURANCE

The Kennedy-Griffiths Health Security Program (HSP) and the Nixon Administration's National Health Insurance Partnership Act (NHIP) are the main legislative proposals before the Congress designed to deal with the nation's health crisis.

There is a basic conceptual difference in the two programs. HSP begins with the assumption that every American has a right to full-cost health care coverage, and then makes certain minor exceptions designed only to facilitate initial operation of the program. NHIP accepts the current patchwork private insurance system, with its complex deductibles and co-insurance, and attempts to ease the

financial burden on the consumer and close some of the existing gaps in coverage.

Following are detailed comparisons of the two programs:

Financing

HSP would be financed through a Health Security Trust Fund, which would replace existing health insurance schemes. The fund would derive 50% of its funds from general revenues, 36% from a 3.5% tax on employer payrolls, 12% from a 1% tax on income up to $15,000 a year, and 2% from a 2.5% tax on self-employment income up to $15,000 a year.

NHIP would be financed through the private health insurance system, with employers required to pay 65% (rising to 75% in two years) of the premium, and the consumer paying the rest. The Act sets up a separate program for the poor, the Family Health Insurance Plan (FHIP) in which the government buys limited insurance for the poorest families ($3,000 for a family of four), and subsidizes premiums (on a sliding scale) for families with incomes below $5,000.

Cost

HEW experts estimate that total health care costs in FY 1974–1975 will reach $92.8 BILLION. Following would be the percentage breakdown of this total if nothing is done, under NHIP, and under HSP:

[In percent]

Sector	Current system	NHIP	HSP
Consumer out-of-pocket expenses	42	36	17
Existing public programs (medicare, etc.)	21	19	
HSP trust funds			68
Private health insurance	22	30	
Federal VA and Defense expenditures	15	15	15

NHIP would merely shift 6% of current consumer expenditures and 2% of public costs to the private insurance industry, and leave intact the current payment-at-time-of-illness system. HSP would establish a pre-payment health care system through the tax structure by replacing current public, insurance, and consumer expenditures with a Social Security-type trust fund. The issue is not cost—since as a nation we will be spending initially about the same on health no matter what happens—but how the money can best be spent to provide an efficient health care system.

Administration and regulation

HSP would be administered as part of the Social Security system. The program would give the government the leverage it now lacks to bring costs under control and order to the chaos that now characterizes the health care system.

NHIP would be run through the private insurance industry, which in itself is part of the cost escalation problem. The Administration initially favored federal cost and standards regulation of the health insurance industry as a component of the plan, but it has backtracked in favor of permitting the states to regulate the industry. NHIP would also permit continuance of the virtually open-ended system of reimbursement for providers of medical goods and services.

Benefit coverage

HSP would provide comprehensive coverage of the full costs of most medical care for every American. Limitations include extended institutional care (120 days), dental care (full cost of accidental injury and full cost of children up to age 15), outpatient medicines and drugs (covered if used in treatment of a long-term condition), and mental health (full cost of 20 psychiatric sessions and full cost of hospital care for 45 days and of day care for 60 days). All other medical goods and services would be fully covered, for rich and poor alike.

NHIP provides no coverage whatsoever for extended institutional care, dental care, podiatry, home services, laboratory and X-ray work, mental health, outpatient medicines or drugs, and prosthetic devices. Inpatient hospital care would be covered at 75% after the first two days, except pre-existing conditions would not be covered during the first 6 months of coverage. All other medical services (outpatient hospital care, physicians, eye exams for children under 12, laboratory and X-ray work, outpatient physical therapy, appliances and medical sup-

plies, and emergency ambulance service) are covered at 75%, subject to a $100 deductible up to a family maximum of $300. Catastrophic insurance is limited to a $45,000 lifetime total after a $5,000 deductible, with restoration of $2,000 a year after the lifetime total has been used.

A separate program with a reduced scale of benefits, FHIP would cover poor families. Those eligible would be limited to eight doctor visits each year, and 30 days of institutional care. The poorest families ($3,000 for a family of four) would pay nothing for the institutional care, but a complex scale of coinsurance and deductibles would apply to families between this level and the exit level ($5,000 for a family of four). The program would not provide any catastrophic insurance. Thus the poor, who are sicker than the non-poor, would be subjected to second class health care.

Medicare/medicaid impact

HSP would replace Medicare, since those over 65 would be covered along with the rest of the population. Most state Medicaid benefits to poor people would be available under HSP, leaving the program as a supplement in states where it provides benefits beyond HSP. States could claim reimbursement for these services.

NHIP would retain Medicare intact, with its open-ended reimbursement formulae which have contributed to skyrocketing health costs. The FHIP portion of the program would cover many but not all families currently under state Medicaid programs, and add some not now eligible—but would result in benefit reductions for such families in states with generous Medicaid programs. FHIP also imposes deductibles and co-insurance on poor families where none now exist, and makes no provision for single poor people.

Section V

GOP LINE AND REBUTTAL

Republicans and Democrats are in general agreement on the existence of a crisis in our health care systems. It took the President until February of 1971—two years after taking office and first recognizing the crisis—to come up with proposals to deal with it. Administration hucksters have lumped these proposals together into a National Health Strategy. This section lays forth Administration claims in the health field with appropriate rebuttals.

GOP line.—The federal share of total public and private health care expenditures has been doubled over the amount during the previous Administration.

Rebuttal.—The data used to support this contention is from FY 1965—before health care financing measures such as Medicare had taken effect. Since 1965, health care financing expenditures have risen from under $1 BILLION to over $14 BILLION. This financing assistance results from Democratic programs of the 1960s. Under guise of "cost-sharing features" the Administration has made repeated attempts to cut back on Medicare and Medicaid eligibility and benefits. Including the increase of over $13 BILLION in such expenditures in a comparison of FY 1965–FY 1972 health spending distorts reality. The comparison in addition takes no account of the 40% increase in medical prices due to inflation in the FY 1965–FY 1972 period.

GOP line.—Federal support to health professional schools has been increased. Strong efforts are being made to provide more family doctors, and emphasis given to the use of allied health personnel.

Rebuttal.—In FY 1973 federal efforts to increase the supply of medical personnel may have increased, but only over the Administration's paltry FY 1972, FY 1971, and FY 1970 requests. Compared to need as determined by authorizing committees of the Congress and medical experts, Administration efforts appear anything but "strong." For medical, dental, and related health professions manpower—the program which provides support for increasing medical personnel supply—the Administration in FY 1973 requested only $331.6 million of $795.5 million authorized, or 42%. For allied health professions training, the request was $35.6 million of $103.9 million authorized, or 34%. With regard to family doctors, President Nixon actually pocket-vetoed the Family Practice of Medicine Act, designed to increase the supply of such practitioners.

GOP line.—The President has advocated a bold program to stimulate growth and use of Health Maintenance Organizations (HMOs).

Rebuttal.—While the Administration did initially support legislation designed to encourage HMO organization and development, it has since backtracked completely and become a major stumbling block to enactment (see page 13). With

"support" such as that now coming from the Administration, HMOs don't need any enemies.

GOP line.—The President's National Health Insurance Partnership Act would significantly assist in reforming the present health insurance structure.

Rebuttal.—Administration hucksters package the Administration's health insurance plan two ways—as national health insurance on the left, and as a sure way to prevent national health insurance on the right. In actuality, the program is a BILLION dollar bonanza for private insurance companies, which would pick up an additional 8% of total health transactions by FY 1974. The Administration has even backed off its initial proposal for federal regulation of costs and standards in the health insurance industry, in favor of state regulation which in many states is non-existent.

The Family Health Insurance Plan portion of the Administration's proposals would consign the poor to second-class health care and result in lower benefits than currently received for the majority of poor families living in the large industrial states with generous Medicaid programs. (For a comparison of the Nixon proposals and the Kennedy-Griffith Health Security Program, see pages 15–18.)

GOP line.—Excess health funds added to the budget by the Congress are inflationary.

Rebuttal.—Refusal to provide funds now to meet the nation's health crisis is itself inflationary. Failure to provide adequate funding for medical education now will worsen the doctor shortage and thereby drive medical costs up in the future. The cost of ill health go beyond direct medical costs—they include loss of earnings and reduced life expectancy, for example. Reduced research funding means that disease gets diagnosed later and treated later, thereby driving up the costs of disease. Spending on health is in fact anti-inflationary, when one compares a dollar spent with the dollars saved as a result of early diagnosis and treatment.

Section VI

KEY HOUSE VOTES

This section contains a selected list of key House votes on health issues. A blank space is provided adjacent to each vote to record how you (if you are an incumbent) or your opponent (if you are a challenger) voted on each key vote. Below the date is the House Roll Call Number of that vote and the page where it may be found in the Congressional Record (CR).

For the 91st Congress votes, an additional reference is included for Congressional Quarterly (CQ), with the CQ number and the page in the CQ Weekly Report where the vote can be located.

For the 92nd Congress votes, the second reference is to the DSG Vote Book number for that vote.

91ST CONGRESS

1. Vote to override the President's veto of the conference report accompanying Medical Facilities Construction and Modernization Amendments of 1969 (H.R. 11102), which authorizes a three-year extension of the Hill-Burton program. Failed 279–98 (D 212–3; R 67–95).

June 25, 1970

CR No. 188, H6039
CQ No. 102, p. 1714

2. Vote to override the President's veto of the conference report accompanying H.R. 13111, the Labor/HEW Appropriation for FY 1970. Although a majority voted to override, the majority was short of the two-thirds required. Failed 226–191 (D 199–35; R 27–156).

January 28, 1970

CR No. 7, H457
CQ No. 3, p. 302

3. H.R. 15931, the post-veto version of the Labor/HEW Appropriation for FY 1970, motion to recommit to the conference committee with instructions to give the President discretion to cut funds up to 2.5% per program. Failed 189–205 (D 40–183; R 149–22).

February 19, 1970

CR No. 26, H1111
CQ No. 13, p. 658

4. Final passage of H.R. 15931, the post-veto version of the Labor/HEW Appropriation for FY 1973. Passed 315–81 (D 216–9; R 99–72).

February 19, 1970

CR No. 27, H1113
CQ No. 14, p. 658

92D CONGRESS

5. Vote on the conference report accompanying H.R. 15417, the Labor/HEW Appropriation for FY 1973, which contained $958 million in increases for health programs. Passed 240–167 (D 202–33; R 38–134).	August 9, 1972 CR No. 309, H7413 DSG No. 217
6. Vote to override the President's veto of the conference report accompanying H.R. 15417, the Labor/HEW Appropriation for FY 1973. Although a majority voted to override, the majority was short of the two-thirds required. Failed 203–171 (D. 181–42; R 22–129).	August 16, 1972 CR No. 333, H7743 DSG No. 236
7. Final passage of H.R. 16654, the post-veto version of the Labor/HEW Appropriation for FY 1973. Passed 324–51 (D 207–6; R 114–45).	September 19, 1972 CR No. 372, H8550 DSG No. 267
8. Giaimo amendment to H.R. 10061, the Labor/HEW Appropriation for FY 1972, to add $230 million in health funds. Failed 169–215 (D 145–76; R 24–139).	July 27, 1971 CR No. 207, H7246 DSG No. 136

Section VII

SOURCE MATERIAL

Budgetary material analysing Nixon Administration health requests available from the Coalition for Health Funding, One Dupont Circle, NW, Washington, D.C., Tel: 202 466–5187.

Health Security Program materials available from the Committee for National Health Insurance, Suite 410, 806 15th St., NW, Washington, D.C. Tel: 202 737–1177.

"Towards a Comprehensive Health Policy for the 1970s," Administration White Paper on health, available from HEW, Washington, D.C.

"Basic Facts on the Health Industry," comprehensive data and charts compiled by the Ways and Means Committee staff, available from the committee office, House of Representatives, Washington, D.C. 20515, Tel: 202 225–3625.

"Health Care in Transition: Directions for the Future," by Ann Somers, available from the Hospital Research and Educational Trust, 840 North Lake Shore Drive, Chicago, Illinois 60611.

"The Proposed HMO Act of 1972," by Rep. William Roy, available from the Science and Health Communications Group, 1730 Rhode Island Avenue, NW, Suite 500, Washington, D.C. 20036.

"Intense Drive by Lobbying Groups Dims Prospects for HMO Legislation," National Journal, September 2, 1972. page 1404.

Discussion of the Nixon Administration health record by a number of Democratic Senators, Congressional Record, September 25, 1972, pages S15753–S15760.

"Our Ailing Medical System," series of five articles in the January, 1970 issue of Fortune magazine, Congressional Record, January 28th, 1970, S740.

"S. 4297—Introduction of the Health Security Act," Senator Edward Kennedy, Congressional Record, August 27, 1970, page S14338.

Mr. METCALFE. You have on your list, Mr. Chairman, Mr. Mose E. Kincaid, and I would like the record to show that he is the director of community services of Quitman County, Marks, Miss., and he is here upon my invitation.

This concludes my remarks. If you have any questions, I will attempt to answer them.

Mr. ROGERS. Thank you for the very excellent statement and for the legislation, which you have introduced. This committee will consider all aspects of it, and particularly those points which you have high-

lighted in your statement. We are grateful for your presence here and for your interest. I share the sentiments that you have expressed.

Mr. Preyer?

Mr. PREYER. Well, I, too, want to thank Mr. Metcalfe, a Member who is not a member of the Public Health and Environment Subcommittee, but you have certainly made a contribution to health programs in this country and we appreciate your help. Thank you.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman. It was a very good statement. We all know him to be a man of good will and that he speaks the truth that is in his heart. We certainly have had many aspects of this legislation very forcefully brought to our attention by your statement and the statement of others, which I have read today, and they all certainly have their effect upon me. Thank you.

Mr. ROGERS. Dr. Roy?

Mr. ROY. Thank you very much. I would like to join with my colleagues in thanking you for your statement, and I have no questions.

Mr. ROGERS. Thank you so much. We appreciate your presentation here today.

Our next witness is Dr. John S. Zapp, Deputy Assistant Secretary for Legislation; (Health), Department of Health, Education, and Welfare.

STATEMENT OF DR. JOHN S. ZAPP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. VERNON E. WILSON, ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION; AND DR. H. McDONALD RIMPLE, DIRECTOR, NATIONAL HEALTH SERVICES CORPS, HSMHA

Dr. ZAPP. It is a pleasure for me to be here today and discuss with you the program of National Health Service Corps and H.R. 16755, a bill to amend and extend section 329 of the PHS Act. The concept of meeting the health needs of residents of areas critically short of health personnel through the provisions of direct Federal medical services has been debated as far back as the 1930's. The majority of heavily populated and economically secure areas of America have adequate access to medical services. However, there are segments of the American population, especially those who live in rural and inner city urban areas, who receive little or inadequate medical care. The "Emergency Health Personnel Act of 1970," Public Law 91–263, which the President signed December 31, 1970, was designed to help meet this problem.

In his health message of February 18, 1972, the President indicated that meeting the special needs of scarcity areas was a key objective of his six-point health program and that a National Health Service Corps would be mobilized to provide health professionals to critical manpower shortage areas. For fiscal year 1972, the administration requested $10 million to staff the Corps with doctors, nurses, dentists, and other allied health professionals who would provide Federal medical personnel on a temporary basis to alleviate the crisis in some of these areas.

IMPLEMENTATION

In mid-June 1971, the National Health Service Corps was created as a distinct program within the Health Services and Mental Health Administration. Regulations and guidelines, which were circulated to a large number of groups and individuals outside DHEW for comment prior to final preparation, were published on December 16, 1971. Also during this period, selections were being made and confirmed for the National Advisory Council required by the act.

The first Corps members were assigned to and deployed in medically underserved areas in January of 1972. To date, the Corps has selected 143 communities to receive Corps assignees. PHS personnel numbering 407 have been or will be assigned to staff these 143 communities; 30 communities are located in urban and 113 are in rural areas. Of these 407 positions, 223 have been allocated for physicians, 34 for dentists, 86 for RN's, and 64 for other allied health professionals. As of October 1, 1972, we expect the approximate number of personnel in the field providing services to total 220; of these, 158 are physicians, 23 dentists, 35 RN's, and four allied health personnel. The remaining personnel are being recruited and will be assigned as soon as possible.

The National Health Service Corps receives applications from communities requesting medical personnel. If the Administrator of the Health Services and Mental Health Administration approves these communities, the previously recruited personnel are assigned to these communities.

Section 329 of the PHS Act, the operational authority for the Corps, provides that the need for services in a given area must be certified by the State and district medical, or dental, or other appropriate health societies as well as the local government. Besides the certification process, recommendations are obtained from State and areawide comprehensive health planning agencies. The procedure for implementing this requirement has been to obtain the signoff by the appropriate society representatives to an application submitted to the Corps. This procedure has worked well in most cases, insuring an effective input by the health professionals who are most familiar with the needs of the areas. The law also requires that a fee be charged to recover the "reasonable cost" of providing the services, except for those who are unable to pay. Third-party payers, including Federal and State health insurance and payment programs, are liable to be billed by the Corps exactly as if the services had been provided by private health providers.

PROPOSALS FOR CORPS EXTENSION

H.R. 16755 would extend and substantially change the Corps' authority for 3 years with authorizations of $25 million in fiscal year 1974, $30 million in fiscal year 1975, and $35 million in fiscal year 1976. At the present time, we are reviewing the existing National Health Service Corps authority to determine what, if any, changes need to be made. The program is relatively new, and careful analysis of the experience to date is required for this review to be truly effective. For this reason, we urge the Congress not to act on the bill at this time. H.R. 16755 contains a number of provisions which are not related to the basic enabling authority for National Health Service Corps activities which we believe are particularly inappropriate for consideration in this context.

LOAN FORGIVENESS

H.R. 16755 would amend section 741(f) of the Public Health Service Act which authorizes loan repayment and forgiveness for physicians, dentists, and other health professionals who enter into an agreement with the Secretary to practice their profession in an area determined by the Secretary, after consultation with the appropriate State health authority, to have a shortage of and need for personnel trained in their professions. It would provide for loan forgiveness to persons serving in the National Health Service Corps at a rate of 50 percent of principal and interest for the first year of service and 50 percent for the second year.

As you know, Mr. Chairman, this administration fully supports the principle of loan forgiveness as a means of providing incentives to practice in underserved areas. Existing provisions of section 741 authorizing loan forgiveness and repayment in return for service of health professionals in such a shortage area at the rate of 30 percent of the first year of practice, 30 percent for the second year, and 25 percent for the third were only recently enacted in 1971, and represent a significant broadening of earlier authorities. While it is too soon to assess the impact of these broadened loan forgiveness authorities, we are hopeful that the increasing numbers of physicians, dentists, and other health professionals will take advantage of the new provisions and practice in such shortage areas. The present 3-year service period may encourage more practitioners to take up permanent residence in the communities in which they serve. In our view, further changes in these provisions before the existing law has had time to operate and before effects of the new laws can be studied and evaluated would be premature.

PHS HOSPITALS

Section 3 of H.R. 16755 would establish a statutory process for notification of the Congress in regard to the Department's plan to convert the PHS hospitals to community management and use. As you know, Mr. Chairman, we have previously stated in testimony before Congress that the Department will not undertake any unilateral action with respect to the PHS hospitals. Let me reiterate that it is our firm intention to conduct appropriate briefings for the Congress in any and all cases when workable arrangements have been developed with respect to the disposition of PHS hospitals and before any final decision is reached. Therefore, we believe section 3 is unnecessary.

Most objectionable is the provision which requires the 314 (a) and (b) State and areawide planning agency's approval prior to any disposition of PHS facilities. We have continuously solicited the review and comments of these planning agencies on the proposals that have been submitted to the Department for the conversion of the PHS hospital to community management and use. Our guidelines stipulate that these proposals must be in accord with the health plans of the community, and we would not accept a proposal which significantly deviates from these established plans.

However, the provision contained in H.R. 16755 would inappropriately give unwarranted and unprecedented authority to a non-Federal agency over a direct Federal program and thus would severely

restrict the Secretary's authority to conduct programs for which he alone bears statutory responsibility.

Most importantly, we remain committed to the position that no beneficiary will be deprived of medical care, no needed resources will be withdrawn from the respective communities, and no final actions will be taken without giving the Congress an opportunity to study them in advance.

SCHOLARSHIPS

The bill would provide scholarships of up to $5,000 per year to individuals who would agree to serve in the regular commissioned corps of the Public Health Service for 6 months for each academic year a grant is received. This provision would appear to go far beyond the scope of the National Health Service Corps and cover the whole range of our health programs. In our judgment, this bill is not an appropriate vehicle for dealing with the Department's across-the-board personnel requirements in the health fields.

Section 5 of H.R. 16755 is also similar to section 784 of the Public Health Service Act, added by the Comprehensive Health Manpower Training Act of 1971. That section authorizes the Secretary to award scholarships of up to $5,000 per student per year, to medical students who agree to practice primary care in a physician shortage area or in a place or facility where a substantial portion of patients served are migratory agricultural workers or their families. Mr. Chairman, we strongly appose this provision of H.R. 16755 as duplicative in the case of physicians, and we believe that the preferred treatment accorded the commissioned corps as against the civil service in the loan forgiveness and scholarship provision of the proposed bill, would be a step in the wrong direction.

With the end of the draft, the Department will be confronted with critical problems of recruiting personnel in these relatively scarce categories for all of its programs, including those involving assignments to remote areas on Indian reservations and to relatively unpleasant duty in Federal prisons as well as those to the National Health Service Corps. The Department is currently in the process of developing a specific plan for meeting its future needs for health professionals with particular reference to the special problems involved in obtaining physicians and dentists. As a part of this process, we are, at the request of the Director, Office of Management and Budget, chairing an interagency committee which includes representatives from the Department of Defense and the Veterans' Administration, and the Civil Service Commission, to examine the executive branch's needs for physicians in the context of overall national needs. Our study encompasses the matters of projected requirements for physician manpower and alternative ways of meeting those requirements, projected levels of supply, and the implications for the Federal and non-Federal sectors, of alternative concepts of compensation and other benefits of Federal employment.

With this study as the basic analytical tool, we expect to be able to submit such legislation as may be necessary to the Congress at the beginning of its next session. In the meantime, we strongly urge that no piecemeal action be taken on this important matter.

CONCLUSION

As I indicated earlier, we are currently reviewing the National Health Service Corps authority at this time to determine what, if any, changes need to be made. This review is part of an overall review of PHS authorities which expire at the end of fiscal year 1973 with a view to identifying necessary and desirable amendments. We anticipate submitting our detailed legislative recommendations in connection with the fiscal year 1974 budget. Accordingly, we request your cooperation in not extending this legislative authority at this time and therefore recommend against the enactment of H.R. 16755 at this time.

Mr. ROGERS. Thank you.

Mr. PREYER. Thank you, Dr. Zapp. You point out that with the end of the draft you will probably have some severe personnel recruiting problems and with that situation I can see why we would have to have better incentives to recruit these people. One of these incentives is the loan we give in this program and, as I gather, your testimony is that you prefer to keep the same 30–25 percent ratio rather than going to a 50 percent the first year and a 50 percent the second year?

What are the results of your experience on these loans under the existing program? Are they working or are they not working?

Dr. ZAPP. I would answer this two ways. On one basis we have had very little experience. As you realize, this was just signed into law in November of 1971. The previous loan forgiveness authority was on a much more minimal dollar basis and the experience on it wasn't very rewarding; but on the other hand, the commensurate incentives for people to use weren't there either.

I think it is really impossible for us to evaluate it now as being adequate or inadequate, or even that the 50 percent contained in the bill is adequate. We do, relating again to your question, very definitely recognize the problem we face with the impending end of the draft, which has obviously been one of the main methods that the Commission or Corps has used to get young physicians and dentists and other personnel into their system. But we have even a broader problem than that in that we have about 45,000 members in the Public Health Service and somewhere around 5,500 in the Commissioned Corps. We have a problem in recruitment and retention of all qualified health personnel in the various programs of the Department, and not only those programs that are served by the Commissioned Corps. We have committed ourselves, and in so doing testified before the Armed Services Subcommittee several days ago that we would be submitting a comprehensive piece of legislation dealing with this problem, not only for the Commissioned Corps but for the civil service medical personnel within the Department as well. We will submit this at the beginning of the next Congress. It is for this reason, not that we necessarily have ruled out some of the options that are contained in this bill, that we have requested deferment of action on it.

Mr. PREYER. What we heard in the past about loan forgiveness, is that it hasn't worked very well. I would think your study may well say that 50 percent is not enough rather than that it is too much, so I think that this bill is probably erring on the side of the lesser recommendations.

The other point I wanted to be sure I understood was on the scholarships. As I understand, you object on the grounds that it is duplicative of the comprehensive manpower training bill which doesn't bother me too much as long as it doesn't mean that we are duplicating the administrative setup, because I don't want us to have two different people at two different desks to man two different programs. Is causing duplication one of your administrative functions?

Dr. ZAPP. Well, I think that could be handled both ways, Mr. Preyer. I think the subcommittee was very cognizant of that factor in the development of the HMO bill that was reported out in seeing that we don't end up with duplicative authority. I would have to say, here again, that I think our objection to the section lies more to the fact that we are trying to review this across the board, and we are simply asking for deferment until we complete our comprehensive study, until the beginning of the next session of Congress.

Mr. PREYER. The other point you make on scholarships is that it is addressed to the whole Public Health Service, as I understand, rather than just National Health Service Corps and, therefore, is discriminatory or something. I think it does give special treatment to Public Health Service, but I thought that is what we are trying to do in order to create an incentive and help you get more people?

Dr. ZAPP. I think, Mr. Preyer, that the committee has very honestly been trying to provide incentives for the Corps. Like I said, we deal within the Department, with a different problem again with the Corps only making up a small percentage of the total Public Health Service employees. Our overall need to recruit and retain high quality, competent people into the Public Health Service becomes a major problem with the ending of the draft. We simply want to be able to address it across the board. We are looking for carrots, too, as a matter of fact.

Mr. PREYER. I agree with you that this is a major problem and we will certainly await your study with interest. I don't think that loan forgiveness and the scholarships are going to answer your problem. But, by the same token, I don't see how these approaches could do much harm right now while we are awaiting your study. I think you are on the right track in making that study.

Thank you very much.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you.

How many counties are there in the United States without a physician?

Dr. ZAPP. About 130, Dr. Carter.

Mr. CARTER. About 130? You have located already 113 rural physicians; is that correct? I mean Public Health Service.

Dr. ZAPP. We have about 153. But, they are not all in rural areas.

Mr. CARTER. I think there are 30 in the rural areas and 113 according to your paper.

Dr. ZAPP. Yes.

Mr. CARTER. In the rural areas?

Dr. ZAPP. Yes, those are projects. We may, in some cases, have an overlap between the numbers of projects and the numbers of personnel but——

Mr. CARTER. Are these counties without physicians?

Dr. ZAPP. Yes.

Mr. CARTER. They are?

Dr. WILSON. There are currently 40 allocated with 18 of those without physicians.

Mr. CARTER. 18?

Dr. WILSON. In counties without M.D's. There are 40 allocated totally.

Mr. CARTER. And 18 have been sent to counties without M.D.'s? Is that what you are saying?

Dr. WILSON. Well let me check the numbers that have been sent out?

Dr. ZAPP. We will refer this to Dr. Rimple who is the Director of the National Health Service Corps. It is an assignment that is just now taking place, Dr. Carter. We wouldn't want to give you incorrect numbers.

Dr. RIMPLE. Actually, there are at the present time, Dr. Carter, 20 counties which are being served by physicians who have been appointed in the Corps through 12 projects. In addition, we expect to allocate an additional 40 physicians to physicianless counties during the current fiscal year.

Mr. CARTER. And these counties are those which have no physicians at the present time?

Dr. RIMPLE. Exactly, sir.

Mr. CARTER. All right. And are you allocating Public Health nurses, also?

Dr. RIMPLE. Yes, sir.

Mr. CARTER. And dentists?

Dr. RIMPLE. Yes, sir.

Mr. CARTER. What is the basic pay of a physician going out to such an area?

Dr. RIMPLE. It varies between $15,000 and $18,000 a year.

Mr. CARTER. Between $15,000 and $18,000?

Dr. RIMPLE. Yes.

Mr. CARTER. Does he get subsistence?

Dr. RIMPLE. Yes, sir. That is the total package.

Mr. CARTER. That is the total package?

Dr. RIMPLE. Including subsistence and other benefits.

Mr. CARTER. I see. How many hours a day is he supposed to put in?

Dr. RIMPLE. The Public Health Service officer is on duty 24 hours a day, 7 days a week.

Mr. CARTER. For work like that, that isn't too much money for a man of his training, is it? And it will be very difficult to get a man to go into a rural area at that price today.

What is the average wage of a master plumber in the United States today?

Dr. RIMPLE. I don't know; but I think it is much higher than that.

Mr. CARTER. I can tell you the last I saw it, it was $19,000 per year and it isn't going down. We can't get these people to go out there and stay unless we increase their pay. We are going to have to do that, aren't we?

Dr. RIMPLE. Yes.

Mr. Carter. What do you think about having a basic allowance, letting him take care of the poor below a certain level and above that level letting him charge and keep the money as part of this?

Dr. Wilson. That obviously is not permissible under the present law. That is not, I believe, an alternative that we have had an opportunity to review. It does have parallels elsewhere in other comparable activities and I think it is an interesting suggestion and ought to have extensive review. I don't know if we are prepared to react to it immediately without having looked at it.

Mr. Carter. Do any other agencies of the Federal Government do this?

Dr. Wilson. Not in exactly that form. There are other agencies of the Federal Government who do have individuals on part pay who are, by agreement, with that Federal agency, able to provide medical services and be compensated for it over and above the pay from the Government.

Mr. Carter. Specifically, you are referring to the Veterans' Administration; is that correct?

Dr. Wilson. The Veterans' Administration in its cooperative program with the medical schools does have a program of this type, yes, sir. That is correct.

Mr. Carter. Well, we must do something because we are not going to get physicians to go out and stay there in the rural areas. The subsistence alone costs a great deal as I see it.

This present bill makes a very generous offer in forgiveness; an offer of $10,000 each year for each year served in a rural area. I would have gotten my medical expenses paid off in a year quite easily if I had benefitted from that because I practiced in a rural area, but still that might not be much of an inducement today. I understand you had some trouble with the area planning groups about getting physicians in certain areas; is that correct?

Dr. Zapp. Not what we would consider as being area planning groups. I am not aware of any problem in that connection, Dr. Carter.

Mr. Carter. Let's see. I believe I marked that on your statement. Maybe I read it wrong.

Dr. Wilson. I believe that the place where there are still a few unresolved problems has been in the contacts with the professional societies, as they address the issue of their own professional group. I believe in every instance where questions have been raised by the planning agencies, to the best of my knowledge those have been resolved. We don't have any of those, I believe.

Mr. Carter. Has this opposition developed where there is an obvious need for physicians?

Dr. Rimple. Yes, sir.

Mr. Carter. I regret that very much. Wherever the need is, I would like us to get physicians.

Thank you very much.

Mr. Rogers. Dr. Roy?

Mr. Roy. Thank you, Mr. Chairman.

Let's pursue a couple of things Dr. Carter was asking about. No. 1, the National Health Service Corps physician is to collect medicaid fees and other fees and insurance that would be available, isn't he?

Does this sometimes exceed the cost of placing the National Health Corps physician in the area?

Dr. ZAPP. I think it would be entirely possible depending upon the number of individuals he was treating, what the State was, what their medicaid allotment was, and so on.

Mr. ROY. What do you do with the excess?

Dr. ZAPP. It all goes to the U.S. Treasury.

Mr. CARTER. You have many instances, where physicians have collected as much as $100,000 a year from medicaid alone, don't you?

Dr. WILSON. Not under the National Health Service Corps.

Mr. CARTER. Well, not under that, I agree, but you don't question the statement that I have made?

Dr. WILSON. No; I have no basis to.

Mr. CARTER. I have many instances of that that I know of.

Dr. WILSON. The direct answer to your question is, "Yes," that if you go on a straight line basis, taking our exact costs—and this is to the issue addressed by Dr. Carter just a few minutes ago—of the level of salary, it leaves you inevitably if you charge prevailing fees in the position of collecting some additional money and that all reverts to the Treasury in one or another of a designed plan. Any excess goes back to the Treasury.

Mr. ROY. Is there any way this is used to compensate the National Health Service Corps for their expenditures in putting the physician there?

Dr. WILSON. No.

Mr. ROY. Does any money go to the community for further improvements?

Dr. WILSON. No.

Dr. ZAPP. No. As of now, it is all turned over to the Treasury.

Mr. ROY. Are there any plans to return any of these moneys to the community?

Dr. ZAPP. Well, I frankly cannot answer that, Dr. Roy. It is one of the many things that we are considering as a process of how we feel that the program should be extended.

Mr. ROY. Is there a possibility that this money will be used to decrease the amount of money recommended by OMB as far as the ongoing programs are concerned?

Dr. ZAPP. It is an option that has to be considered; yes.

Mr. ROY. In most of these areas I would expect—well, certainly in a number of these areas, these programs are going to be self-sustaining or making an additional amount of money even in the underserved areas where, perhaps, only 50 percent of the population can pay. If you are in an underserviced area, I would anticipate that you might well have an excess at the end of the year.

Dr. ZAPP. That is very likely, especially if you were treating in an innercity area, where you had a reasonably rich package of benefits under the State medicaid program. In the rural areas, where there isn't the density of population and there may not be the same type of coverage for medicaid benefits, that may not be the case.

Mr. ROY. At the present time then, you can't retain the excesses?

Dr. ZAPP. That is correct.

Mr. ROY. And your future plans for this excess money are uncertain?

Dr. ZAPP. Well, there is a provision attached—or there was, I should say—in the beginning of fiscal year 1973, other HEW, Labor Appropriations, a point of order language that I think Dr. Wilson could explain, because as you realize that is not current authority within the Department.

Mr. ROY. I ask you to do this: If you can't explain today, would you let us know what the plan is to do with the excess money; whether you wish to return it to the Treasury, whether you would like to balance it against your expenses, or what? I would like to know.

Dr. ZAPP. Yes. We would send you the full chronology of what we went through before the Appropriations Committee on that point, Dr. Roy.

(See item No. 4 Budget, fourth question and answer, option No. 2 of "Answers to questions submitted by subcommittee," p. 77, this hearing.)

Mr. ROY. Do you have any idea at the present time how much money will be generated by these programs in fiscal year 1973?

Dr. WILSON. No; we basically do not. I think as you recall, the Secretary has testified in the event our predictions in the 1973 budget were to be overly optimistic that we would come back and ask for supplemental, up to the full amount that was intended. So that we simply do not know what those earnings are apt to be and will only know after a period of time.

Mr. ROY. What is your request for fiscal year 1973?

Dr. WILSON. $15 million.

Mr. ROY. And do you have any idea what your requests will be for fiscal year 1974?

Dr. WILSON. That is still unprocessed.

Mr. ROY. Can you tell us about how many health manpower shortage areas there are in the United States?

Dr. WILSON. In response to the admonition that was really in the amendment, we have, in fact, undertaken an intensive study trying to determine how one would delineate what our manpower shortage areas are. That is not a very simple task. We will be able to report on approximately the 1st of October, or about the 1st of November—the middle of October or the 1st of November. We will be able to report on about 600 such communities that have been worked out on a system that we believe is going to be helpful; namely, to look at a series of factors that are taken into account in determining manpower shortage and then adapting them to the specific piece of legislation which is concerned with shortage. Mental health, for instance, which has a concern with one type of shortage, may have a different problem there, than one may have under the National Health Service Corps or another act. And we think we will have a report that will have that job perhaps 50 percent completed by the first of November with the chance by the first of the year of having it pretty well reported out on all requests that we have had.

Mr. ROY. Do you envision this program as a program that is going to meet the health manpower shortage needs in each of the areas that you identified?

Dr. WILSON. The National Health Corps?

Mr. ROY. Yes.

Dr. Wilson. At the moment, I think there is no way to envision this program as totally meeting a kind of need that will be uncovered in the storage areas simply because of the order of magnitude on that need. And I think we have two processes in place. One, this program which, within its limits of people and resources, will meet needs and we will learn more about how one goes about meeting needs. The other program, of course, is to try to identify the total needs and that we must be very careful in contacts with the work by the Mental Health Bureau of Manpower.

Mr. Roy. The other thing that Mr. Preyer was asking you about was the number of areas in which professional societies have failed to give approval to the placement of health personnel. My distinguished colleague, Mr. Metcalfe, told us there were approximately 17 physicians and 16 dentists that have not been assigned because of the objections of professional societies. Dr. Rimple answered that he felt, on occasions, these had been capricious decisions. What do you think we should do, as far as the legislation is concerned, about this?

Dr. Wilson. I am not sure we would accept "capricious." I would say the decisions were made on a basis with which we don't agree.

Mr. Roy. At least you feel the decisions were wrong; that there was a justified need in these areas for the assignment of personnel?

Dr. Wilson. In most instances, yes. But I would like to make two points——

Mr. Roy. In most instances or in all instances?

Dr. Wilson. I am not sure we possess the informtaion to say "all."

Mr. Roy. The only reason I asked is why in the world would you people be putting personnel there if there wasn't any need?

Dr. Wilson. I guess there are two possibilities: One, of course, we may have made a mistake. I am continually being educated by people when I thought I was right. And I think that is possible for an agency as well. And the other, of course, is that maybe time was the factor rather than the issue at hand of whether there was need.

May I make two other points in response to this? One, I would like to make it clear that in our opinion, although it may have changed the community to which we went, we have at the moment, really not had the problem of having personnel who could not be sent to a community of equal need and so while a specific community may have had difficulty, we have not yet had an instance where someone in need was unable to take all of the help we could give.

Mr. Roy. What you are saying is, there might be a problem of this in the future, but——

Dr. Wilson. It is a question in principle rather than a question of absolute robbing someone of a right that they may have had.

Mr. Roy. Well, we regret that this should be happening. What should be done about this? Should this requirement for a signoff, so to speak, by a professional society, remain a requirement?

Dr. Wilson. My impression—and I will yield to someone else—but my impression is that if, in fact, we are talking about establishing a viable health care entity and because we are dealing in an area that already has a shortage of manpower by definition, that if, in fact, we force someone into that area without having the cooperation of the other professionals, you are very unlikely to establish a viable health care mechanism under that setup. We would much prefer to attempt

to work this out on a professional basis, because we believe that over a period of time it is going to be possible to bring an understanding about.

Mr. Roy. Should there be a right of appeal to the Secretary?

Dr. Rimple. I would like to add to Dr. Wilson's comment, Dr. Roy, that while it is true we have run into situations such as those that you describe, we have found that by working with the community and with the medical society behind the scenes and trying to find out what the reasons are, we have been able to bring about a resolution of these problems whereby there was, at first, a resistance to certification. And I think this is going in the right direction. To date we have had some seven approvals from societies which originally refused, and this was brought about by this manner of negotiation and trying to find out what is really going on. And we have had seven out of 31 for the dentists, so that I believe that this kind of a negotiation and dialog can bring about results.

Mr. Roy. How many physicians?

Dr. Rimple. Well, there were 31 dental society refusals and of those, through this methodology of discussing and so on, we have been able to get seven approved.

Mr. Roy. And with regard to medical societies?

Dr. Rimple. Of 24 refusals, we have been able to get seven retractions. This is a sign in the right direction and, in that connection, I say that working with the AMA and the NMA, they have helped us in trying to bring about such a resolution.

Mr. Roy. Let me ask you the question directly then. You do not feel that an appeal to the Secretary is necessary? You don't think the Secretary should have the option, in unusual cases, of overruling the professional society?

Dr. Zapp. I think I would probably have to answer that, Mr. Roy, and our position is, certainly not at this time. And I would like to add one other thing——

Mr. Rogers. Now, just a minute. What are you going to do? If you have made the determination you need doctors there and if you have a few who say, no, do you mean you don't want to resolve that?

Dr. Zapp. Well, Mr. Chairman, as a matter of fact, we do want to resolve it.

Mr. Rogers. How are you going to do it unless you provide some mechanism?

Dr. Zapp. We are considering an extension of the legislation. What I would like to point out as part of the legislative history, one of the intentions of this program by both bodies of Congress as well as ourselves, was to create an environment hopefully where some of these members of this Corps would stay in that community and practice medicine. And if we force somebody in at this early stage, true the power of the Federal Government can see that he stays there and practiced but certainly when his 2 years are up, he is not going to feel a part of the community and want to stay and make his life there. And that is one of the things that we are trying to create as a part of this program.

Mr. Rogers. That may be true of some of the people who didn't want him there, but maybe all of those he served would like him to stay.

Mr. Carter. Mr. Chairman, would you yield on that?

Mr. Rogers. Yes.

Mr. CARTER. The only way at the present time they could do that would be to change the law at the present time. They can't do it under the present law, is that correct?

Dr. ZAPP. That is correct, Dr. Carter, and like I say, all parts of the current statute are under review. This particular part of it has received a great deal of discussion and, obviously, it is one of those to which we are giving a great amount of attention. But where we have so many areas, so many more than can be met by the Corps—I think we all realize that, if a person is able to pick and choose, obviously he would want to pick those communities in which the environment may allow us to be able to match the man and the community in the hope that he will stay there when his time is up.

Mr. ROGERS. Well, that is all very nice theoretically, but it doesn't give care to those people who need it.

Dr. ZAPP. Well, there are simply so many people who we must give care to, Mr. Chairman. It is not a matter of us having more people to be able to give care in those areas than we have areas to serve, or an equal amount. We have far less people.

Mr. ROGERS. That is simply because you haven't proceeded rapidly enough and we are trying to extend the law whereby you can do that. That is the purpose of this legislation. If we are not going to expand, and you don't want us to do anything, then of course you can't give these communities service but that is what this committee is looking into; namely, how to provide it.

Dr. ZAPP. Well, I hope I have not miscommunicated a feeling on this, Mr. Chairman. We are not saying we do not want to do anything in the future. We simply say this, along with our other authorities it is under review and we would simply like to wait until the Presdent submits his budget and legislative proposals in January.

Mr. ROGERS. That doesn't get to the answer, either.

Dr. ZAPP. But there is another area of recruitment that I think the committee would like both Dr. Wilson and Dr. Rimple to speak on.

Mr. ROGERS. No, I think the committee understands the situation. We understand what we need to do. I understand you are not willing to say what we need to do.

Well, go ahead.

Mr. ROY. Yes. I might add I have a very strong bias in favor of the professional communities giving this consideration. I again regret that, apparently, somebody made a mistake somewhere along the line on a large number of communities. I hope that the desire of all of the physicians in the community would be to see that proper medical care is given. I also have seen what is happening in the Midwest, Kansas, and Nebraska. I have seen a very high degree of cooperation by local physicians and I praise them very highly for this. I am sure this amount of cooperation should be stressed rather than the exceptions that we are talking about.

But I also know that as we rewrite this legislation, we should consider some appeal so that the community can speak and not just the one physician or one dentist. I picked up a Texas paper the other day—I think it was the Star County, Texas, where there were 17,000 people and one physician. I would hate to think that one physician could block any further physicians from coming in there under the National Health Service Corps.

Mr. Chairman, if there is time, there is one more area of questioning I would like to pursue. What happens at the end of the 2 years? We have some of these projects running to 1973. Is the National Health Service Corps permitted to place personnel longer than 2 years.

Dr. Zapp. Not at this time, Dr. Roy, does the commitment go beyond 2 years. Again, I think this is one of the things that with the early implementation of this act we have under review.

One of the things that is examined when National Health Service Corps personnel are put into this area is the willingness of that community to cooperate to see that that community becomes self-sufficient. From our perspective, this is not the type of thing where we are looking for the Federal Government to be out with a direct delivery of Federal health care. We want to work with those communities where they will work with us and with themselves to meet those needs.

Now, whether 2 years is long enough or not is a question that we have under evaluation and our experience to date isn't adequate to respond either way.

Mr. Roy. Isn't it possible that putting two physicians, for example, and other health professionals within a given under-served area may change the care pattern in such a way that you actually do more harm over a period of 25 months than if you hadn't gone in there at all? Shouldn't there be some consideration to either reassigning additional health personnel? I, of course, share with you that there must be some action on the part of the community making an effort to retain these individuals after they get out of the National Public Health Service Corps. I guess the answer always from you is that you have all of these things under consideration. Can you tell us which way you are leaning?

Dr. Zapp. No, I can't. I think Dr. Wilson would like to comment.

Dr. Wilson. I think, Dr. Roy, we really have to look at each of these communities as we approach the end of the second year on an individual basis. The concern you are expressing that a community not be abandoned after we have established a pattern has to be uppermost; that once you set up a health care system, we have to look at that and not abandon the community. But the answer to that is not yet evident to us because we don't know how successful we have been in matching communities with people who want to stay there and it would be premature for us to say we are going to send additional people in, or whether we have to provide an allied health support system. For instance, in Oklahoma in the Shattuck area, there is a pretty substantial system beginning to build down there, where highly skilled professionals in a relatively small community are serving that area. That may be one of the alternatives for us to turn to. I think it would be premature for us to say, if we sent in two physicians now, at the end of 2 years they would leave and we would send two more in. I think it is not premature for us to say if we start a health care system of some kind, we have an obligation to assist them in making the transition.

Mr. Roy. To what degree is the so-called fiscal self-sufficiency of a community used as a criteria for determining whether you assign Corps personnel?

Dr. Wilson. It is just one of the several criteria. We would not hesitate in some instances to accept a community which had little or

no immediate chance to become fiscally viable, but if we had two communities with equal need, one of which would be more apt to become fiscally self-sufficient, than the other, and the need was apparently the same to the best of our ability to measure it, then we would accept the one that was most viable fiscally, as long as we have a limit anyway on the number of resources we have.

Mr. Roy. If my understanding is correct, the law is you are supposed to be making the decision on the basis of need and not on the basis of fiscal viability?

Dr. Wilson. Yes, but at the moment we are dealing with such a small portion of the total priority of need, that we still can take this other consideration into account without denying the basic premise of meeting needs as such.

Mr. Roy. Isn't it almost inherent in a situation where a community is not going to be fiscally viable that it has a greater need than a community that may be fiscally viable?

Dr. Wilson. No.

Mr. Roy. Again, the people who did not have the ability to pay, have very little chance of attracting any personnel other than assigned personnel. This doesn't mean that there might not be 5,000 of them——

Dr. Wilson. Well, I think the 130 physicianless counties would be found to have a comparatively low correlation with fiscal need as such. There is another factor operative there and I just don't think you can generalize and say that because there is need for health manpower that it has a total 1-to-1 correlation with lack of a capacity to——

Mr. Roy. I know it doesn't have a 1-to-1 ratio.

The 144 communities that you sent personnel into, how many of these have good potentials for self-sufficiency and how many have poor potential for self-sufficiency?

Dr. Rimple. I would say, Mr. Roy, that between 65 and 75 or more have good potential, but again, as Dr. Wilson says, it is too early to make any definitive statement as to whether or not this is true. Two or 3 years down the road, we will know, but on the basis of projections and the information that we have I would say it is about that number.

Mr. Roy. Do you anticipate that there will be a recommendation from HEW for incentives equal to that which we may see in the armed services for physicians going into the public health care in civilian jobs? Do you expect your bonuses and your scholarships to parallel the armed services bonuses and scholarships?

Dr. Zapp. You might say if you put the manpower item on the open market, we are dealing in a very competitive market.

Mr. Roy. I know that, but I want to know what you are going to do about it.

Dr. Zapp. We had and did, before the Senate Armed Services Subcommittee on H.R. 14545, requested that the Commission Corps be treated in section 311(a) the same as the military, the uniformed military service. We did at that same time say that we hoped we would not have to use that authority because we feel that we have an in-house process that is going on with the potential for developing more of a single medical or health personnel system within the Department that will provide the incentive that we need. It may be a little different than the military but we think in general, they have to be competitive.

It could be the differences between training opportunities, retirement and some of these factors. Perhaps the base pay from month to month may not be exactly the same in longevity; but on balance, if we don't come out with equal incentives, we are not going to have equal employment opportunities and we need the manpower as badly as they do.

Mr. Roy. One last question. Are you turning back any appropriated funds?

Dr. Zapp. Are you talking about in the National Health Service Corps?

Mr. Roy. I am talking about the National Health Service Corps.

Dr. Zapp. Dr. Rimple informs me that in fiscal 1972 $5 million was not used.

Mr. Roy. Is that money still available to be used?

Dr. Rimple. We don't have that availability because of the appropriation language.

Mr. Roy. I regret hearing that because I think the chairman and others on this committee were very much aware of the needs and we were rather anxious for you to get started back in 1971 when I first came to Congress. I think this area is so great that it is, in my opinion, regrettable that we didn't get on with it sooner. And I thank you very much for testifying.

Mr. Rogers. I have some questions that I would like quick answers to.

The budget for fiscal 1972 is what?

Dr. Wilson. $15 million.

Mr. Rogers. For 1973?

Dr. Wilson. The same thing.

Mr. Rogers. And you don't know yet what it will be for 1974?

Dr. Wilson. That is correct.

Mr. Rogers. And you turned back one-third of the budget in fiscal 1972?

Dr. Zapp. That is correct.

Mr. Rogers. What was the reason for that? Was that because OMB did not permit you to spend it or because you didn't develop your program?

Dr. Rimple. Because we didn't develop the program in time to use it, sir. We only had about 6 months or less to spend it in. There is no authority to carry it over.

Mr. Rogers. When was the law originally signed?

Dr. Zapp. December of 1970, Mr. Chairman.

Mr. Rogers. 1970?

Dr. Zapp. That is correct. The next to the last day, or the last day of the year.

Mr. Rogers. And this is a 1972 budget that you turned money back for?

Dr. Wilson. That is correct, Mr. Chairman, and as we. I think, one time before had discussed and as I believe the Congressman pointed out a few moments ago, the primary intended use of this money is for the salaries of professional people. The decisionmaking by the professional people, as you read in your opening statement, is about this time of the year. We received that money in 1970 and early 1971 after the majority of the young professionals had already made their career plans for the year 1972.

Mr. Rogers. But you had received $3 million before that?

Dr. Wilson. I understand that, but I am saying, we received the $15 million to which you allude after the time when the career decisions had been made, and it was a matter of recruitment of personnel.

Mr. Rogers. How many of the Federal funds will be obligated and used in fiscal 1973? Will all of the funds be used?

Dr. Zapp. Well, it is certainly our intention. As you realize, we don't have a fiscal 1973 budget yet and we don't know the amount. It is our intent to use the $15 million; yes, sir.

Mr. Rogers. You would plan to use it all?

Dr. Zapp. Yes, sir.

Mr. Rogers. The revenues generated by the profession go to Treasury and you don't see those at all?

Dr. Zapp. That is correct, Mr. Chairman.

Mr. Rogers. How much money have you budgeted for recruitment and how much are you currently using for recruitment?

Dr. Rimple. There is no specific breakdown, Mr. Chairman, for recruitment. The budget is based on the number of projects we think we can fill in a given year, and the number of physicians that we think we can recruit to meet those needs. There are other areas of expenditures which make up the total budget. The biggest part of the budget is for the actual salaries of the assignees.

Mr. Rogers. So you are not trying to recruit, is that it?

Dr. Rimple. Oh, no; not at all. That is not true.

Dr. Wilson. Our recruitment program for the Public Health Service is a separate activity being carried on in which National Health Service Corps and the Public Health Service hospitals and the Indian Health Service and all of the rest, all participate; and we, in fact, have people at the present time who are visiting medical schools, throughout the United States, talking to young individuals.

Mr. Rogers. How many are doing that?

Dr. Wilson. I believe we have something like 45 or 50 people.

Mr. Rogers. Trying to recruit for this?

Dr. Wilson. They are making personal visits in the medical schools, all of the medical schools in the Nation, unless denied admission, and spending 1 to 2 days talking to them.

Mr. Rogers. How many do you plan to recruit for fiscal 1973 and fiscal 1974?

Dr. Rimple. In fiscal 1973 we plan to recruit 91, which will bring us up to the total ceiling.

Mr. Rogers. And who puts the ceiling on?

Dr. Rimple. You do, sir. The Congress does.

Mr. Rogers. On personnel or by money?

Dr. Rimple. Both. I think both.

Dr. Wilson. Both.

Mr. Rogers. We put a limit on personnel?

Dr. Wilson. Yes; there is an item in the budget which says there will be x number; in this case, 660 people is the limit established by Congress.

Mr. Rogers. That is in OMB. That is not written in our legislation.

Dr. Zapp. No; but it has been accepted by the Appropriations Committee as an operational level by the Department and was part of the budget justification as submitted to the appropriate Members in Congress.

Mr. Rogers. So you are going the 660 level?

Dr. Zapp. Well, we are going for the 660 ceiling in fiscal 1973?

Mr. Rogers. And I thought you said you were only using about 400?

Dr. Wilson. All right. There are three different figures with which we need to deal. One is the number of people who would be required to fill the positions in the communities already approved. Now, that 409 approved positions is in excess of those we have on hand by about 180 people. So at the moment, the ceiling is not a problem.

The initial approval of personnel for the National Health Service Corps was 660. As we have looked at shortages here and elsewhere and because, as you know, we operate under a total limit, we have said unless or until we come up to a level of 637 we would consider that to be the limit.

Now, at the point we would have the full 637 filled, we are still mindful of the admonition we were given to move on up to a higher limit and we would have to review it at that time, but that is not a problem at the moment.

Mr. Rogers. Well, I can see your limit is not a problem because you haven't anywhere reached it. Now, why haven't you reached it?

Dr. Zapp. Well, I think I can turn this problem more specifically over either to Dr. Wilson or Dr. Rimple, Mr. Chairman. I think essentially it is the thing we have been stating; namely, the incentive for the individuals to join the commissioned corps at this time. A very high percentage of the people who are recruited into the Department, into the Commissioned Corps, are serving in lieu of their 2 years of draft time. With the impending end of the draft at the end of this fiscal year, at least as it is now planned, the incentive and the lower number of military physicians and dentists that have been drafted into the military have provided less and less incentives for people to come into the Commissioned Corps to serve their time there in lieu of doing it in the military service. Once they come in, there is also a situation of people wanting to take this particular assignment over others. It is not simply a matter of us going out on the campuses with 30, 40, or 50 recruiters and bringing back all of the numbers we need. The existing law is, under selective service regulations, the military is first to call, and——

Mr. Rogers. Has licensing been a problem?

Dr. Zapp. I would have to turn that over to Dr. Rimple. I don't think so.

Dr. Rimple. Not specifically, sir. We have been able in cases where the State has not approved the person, to have him serve on a temporary license basis until the State has approved his license; that is, his application for a license.

Mr. Rogers. How many of the spots or positions are being used in, let us say, your office, Dr. Wilson?

Dr. Wilson. I think none, specifically, at the moment in our office. There are a substantial number of individuals, however, that have been employed, for instance, in the regional office because we have been under some pressure to see if we couldn't come up with a system that was more sensitive to the local regional area. So we are employing people out there to see if we can do our recruitment in those areas. We have for training, field support, and technical assistance purposes,

I believe, 137. There are 137 people involved in training. I believe there are 60 on your staff; is that correct?

Dr. RIMPLE. Fifty.

Dr. WILSON. Fifty on Dr. Rimple's staff, and the rest are in the regional offices and are employed for support services.

Mr. ROGERS. What do you have to do to train people? I thought they were doctors already; are they not?

Dr. RIMPLE. Well, the fact is, Mr. Chairman, that most, if not all, of our assignees are just fresh out of their internship and have very little experience in running an office. Therefore, support services to make this possible so that they might be able to become viable projects requires the training and support services in such subjects as management and in other expertise which they don't have, and which are not taught in medical schools.

Mr. ROGERS. You mean you wouldn't just put a nurse in there and let her run the records? Does the doctor have to do all of that?

Dr. RIMPLE. The doctor doesn't run the records, sir, but he must, with his team, be able to develop a system that is viable, that is based on sound managerial principles——

Mr. ROGERS. How long does it take to train them?

Dr. RIMPLE. Our plan calls for approximately 3 to 6 months on an onsite basis.

Mr. ROGERS. How many are in training now, did you say?

Dr. RIMPLE. All of them.

Mr. ROGERS. Everybody is in training?

Dr. RIMPLE. All of the physicians are.

Mr. ROGERS. So nobody is out in the field?

Dr. RIMPLE. Oh, they are in training onsite.

Mr. ROGERS. So you are doing onsite training?

Dr. RIMPLE. Onsite.

Mr. ROGERS. Well, go ahead.

Mr. PREYER. You may have covered this, but I am not sure it is clear on the record. How many physicians have been authorized by OMB?

Dr. WILSON. 637—no: OMB has authorized 660. Yes; 637 would be the number we currently have allocated, at least until we reach that limit.

Mr. PREYER. How many are actually practicing in the field of that number?

Dr. RIMPLE. 153 physicians to date.

Dr. WILSON. But, the 660 relates to the total number so that is the other number. Total number in the field, there are 409 allocated; and what is the number in the field?

Dr. RIMPLE. The total number is about 220.

Dr. WILSON. 220 in the field.

Mr. PREYER. How many physicians are being used for administration in the field?

Dr. RIMPLE. 137.

Mr. PREYER. How many of those are full-time National Health Service Corps people?

Dr. RIMPLE. All of them are full-time Service people

Mr. PREYER. They are all?

Dr. ZAPP. Mr. Preyer, I think we may want to correct one of those numbers for the record. The 137 would be out of the total ceiling in

which all of these positions have not been filled, and I think we would have to look at the record and see exactly how many filled positions are being used for administrative purposes, including the training at this time. But it would be a lesser number, and——

Mr. Carter. Mr. Chairman, would the gentleman yield?

Mr. Preyer. Yes.

Mr. Carter. So you have already just in administration alone 137 physicians; is that correct?

Dr. Zapp. If they had recruited in full strength for the Commissioned Corps, 137 of them would be used for the training, administration, and for what you might call the nonpractice side of the Corps.

Mr. Carter. Do you feel that physicians should occupy these slots instead of medical administrators?

Dr. Wilson. No, these are not physicians, these are total numbers. We will have to kind of sort out when we are talking about physicians and when we are talking about total numbers. The 637 is the total number of all kinds of individuals; and of that 637, exactly 137 have been earmarked to deal with the administration support training, and only a portion of those would be physicians. The rest would be other kinds of support staff.

Mr. Carter. 137 are detailed to the administrative training; is that correct?

Dr. Wilson. Yes, to handle technical assistance onsite or to do training of the people onsite; and, of course, there is a Corps staff who has to handle the program and be sure we can appropriately report to you and to others about it.

Mr. Carter. What part of this 137 are physicians?

Dr. Rimple. I would say not more than about 10 or 15 at most.

Mr. Carter. Not more than 10 or 15?

Dr. Rimple. Yes, sir.

Mr. Carter. Do you have difficulty in your recruitment at the present time?

Dr. Wilson. Yes, severe difficulty, and this is the point that has been sort of running through the thread of the conversation. It is not a shortage of money at the moment or shortage of position allotments, but our capacity to recruit in a professional field that has delayed our getting our program underway.

Mr. Carter. I see you are shooting at 637 slots for physicians?

Dr. Wilson. No.

Mr. Carter. How many slots?

Dr. Rimple. Approximately 220 physicians.

Mr. Carter. 220 slots for physicians? Do you have that filled?

Dr. Rimple. No, sir. As we said in the testimony, there is a crucial time in the cycle of 1 year in which we can recruit physicians, and that is October and November of the year before they go on duty. That is why we were not able to bring on more than 26 during the November and December period of last year. However, in our recruitment for fiscal 1973, we were able to recruit 159, and we hope to do the same thing during the next month in order to bring ourselves to full strength next July.

Mr. Carter. What are the difficulties? What are the troubles with recruitment? Why can't you recruit them?

Dr. RIMPLE. Because they are only available at a particular time in the cycle; that is, once a year. In between, we are able to recruit one or two but not very many.

Mr. CARTER. Does the salary have anything to do with it?

Dr. RIMPLE. That probably is one of the factors.

Mr. CARTER. Is it much of a factor?

Dr. RIMPLE. Well, it is difficult to say how much but I am sure it is and this can be borne out by comparing those that go into the private sector and those that go into the Commissioned Corps.

Dr. WILSON. I think Dr. Carter, I would not like to leave this committee with the impression that we believe that the only factor operative is salary. We think it is an important factor but another crucial factor with the removal of the draft incentive has to do with the way young men value the use of their time for their professional advancement, and at the moment, in the Health Service Corps we do not have an opportunity for their advancement in any of the specialty areas. There is no residency, training, or professional advancement incentive in that program. Now, that is something which is difficult to come by, but it is one of the factors with which we have to deal with when we deal in a totally open market because these young men are already $10,000 or $15,000 in debt. They are already anxious to get established in whatever specialty they pick and to spend 2 years, which, in essence, is a detour of the road to getting their certification, is a deterrent.

We don't know which of those two factors is the most important and we must deal with both of them.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. How many have made application—how many communities have made application for the Corps?

Dr. RIMPLE. I think there are on the record over 1,000 applications.

Mr. ROGERS. Over 1,000?

Dr. RIMPLE. Yes, some of them are formal applications, and some of them are inquiries leading to an application.

Mr. ROGERS. And what do you think of your ability to recruit if funding is provided? Can you go ahead and recruit to take care of these thousands of communities?

Dr. ZAPP. I think, Mr. Chairman, based on the experience that we have had to date, that hopefully something will come out of the process that we have been going through now, something providing new incentives for health personnel in the Department. I don't think the track record to date would indicate in the foreseeable future that we would be able to serve through the National Health Service Corps all of these thousands of communities.

Mr. ROGERS. Have you tried any unusual recruitment activities?

Dr. ZAPP. I would have to ask Dr. Rimple about that.

Dr. RIMPLE. Unusual recruitment activities? We promise that during their 2 years, in addition to their salary and the alternative of not going to Vietnam, that we would provide them with the wherewithal to become better practicing physicians. We establish relations with medical schools and medical centers so that they can have privileges on the staff. We provide opportunity for seminars and other training during their 2 years, and we also provide opportunity for intercommunications, one with another, so that they can share their experiences and maximize their strengths and minimize their weaknesses. These are

some of the intangible ways in which we attempt to lure them to the program.

Mr. Rogers. Have you arrangements with the medical colleges or with the Association of American Medical Colleges to carry on training programs for them to have associations with the medical centers? Have you approached the association on that?

Dr. Rimple. Yes, we have, and we are still working out relationships by which this methodology can be put into force. We have a variety of methods including the private sector of medicine as well as our own Federal agencies; namely, the VA and the Department of Defense and others, and the various professional societies. We are looking at the broad range of relationships, both in a private sector and in the Federal agencies to maximize their experiences professionally.

Mr. Rogers. Well, I have a number of other questions, but the hour is late. Mr. Hyde, would you give a list of those questions and let them submit them for the record.

(The following information was received for the record:)

Answers to Questions Submitted by the Subcommittee

1. PROGRAM STAFFING

Question. How many positions have been authorized by the OMB?

Answer. OMB authorized 660 positions. The present HEW allotment taking into account general personnel reductions is 637.

Question. How many health professionals are presently practicing in scarcity areas?

Answer. At this point in time, National Health Service Corps has committed 409 of its total of 500 field positions for health professionals to practice in scarcity areas. Of these 409 positions, 224 are allocated for physicians, 36 for dentists, 93 for nurses, and 56 for other allied health professionals. On October 1, the number of personnel in the field providing services was 220, 158 physicians, 23 dentists, 35 nurses, and 4 allied health professionals. The remaining personnel will be recruited and assigned as soon as possible.

During the remainder of FY 1973, National Health Service Corps will be committing the remaining 91 field positions to newly approved communities for a total of 500 field positions. In utilizing these 91 positions, the Corps is placing a priority on projects that would serve physicianless counties.

Question. How many positions are being used for administration? Of these how many are located in the National Health Service Corps and its offices?

Answer. Out of the total Corps ceiling for FY 1973 of 637 positions, 500 are allotted for field positions to be filled by health professionals and 137 for administrative and technical assistance positions. Seventy positions are allocated to the ten regional offices. Sixty-two positions have been retained within National Health Service Corps central office. Five positions have been reserved for specific intensive training in which National Health Service Corps nurse assignees will be trained for expanded roles as nurse practitioners at Cornell University.

2. NHSC COMMITMENT TO COMMUNITIES BEING SERVED

Question. How many communities are presently being served by the National Health Service Corps?

Answer. At this point in time, the Corps has selected 144 communities to receive Corps assignees. Of the 144, 114 are rural projects and 30 urban projects. Twelve projects will provide services to twenty physicianless counties.

On October 1, there were 113 communities which had received some or all of their assigned National Health Service Corps professionals.

Question. How many of these will complete their period of support this fiscal year and stay in the communities?

Answer. At the present time there are 16 approved communities where one or more health professional assigned are intending to leave the National Health Service Corps in July 1973. In each case, at the present time, we intend to recruit another professional to fill those positions when they terminate. These

communities are predominantly ones which were approved in our first review in December of 1971. In the future, six months prior to such anticipated terminations, each project will be reviewed with regard to its ability to keep such personnel themselves on a self-sufficiency basis. Following that review, decisions regarding replacements will then be made.

3. CRITERIA FOR SELECTION OF COMMUNITIES

Question. What criteria are being used to select communities for placement of health manpower? Particularly, are any criteria other than the communities' need for health manpower being used?

Answer. Other than community need, the National Health Service Corps investigates the potential self-sufficiency of a proposed project during the approval process. This is done in an attempt to bring in the projects in a sequential manner so that they will reach maximum possibility of being financially independent of the Federal Government.

Question. If so, with what legislative authority?

Answer. The legislation is silent on the issue of self-sufficiency as such, although it does require the establishment of rate charges for services provided. The statute also clearly speaks to need. In our opinion, there is no conflict between these considerations so long as the point of departure is need and the communities selected meet that basic criteria. The potential for development of a self-sufficient health care system should certainly not preclude a needy community from receiving NHSC assistance. To the extent this potential can be realized, available resources for NHSC activities can be continually expanded and new areas can be phased in as capacity permits.

4. BUDGET

Question. What is the National Health Service Corps budget for fiscal year '72, '73, and '74?

Answer. The National Health Service Corps budget for fiscal 1972 was $14,274,000. This amount included the $3,000,000 in carryover funds from FY 1971. In FY 1973 the budget request is $8,998,000 in budget authority and $6,385,000 in reimbursable authority for a total of $15,383,000 in obligations. The FY 1974 budget is currently being developed.

Question. How does this compare with our authorizations?

Answer. The National Health Service Corps authorization was $10,000,000 for the fiscal year ending June 30, 1971; $20,000,000 for the fiscal year ending June 30, 1972; and $30,000,000 for the fiscal year ending June 30, 1973. No authorization has as yet been enacted FY 1974.

Question. How many Federal funds will be obligated and used in fiscal year '73?

Answer. The Corps will obligate the total $8,998,000 in Federal funds or budget authority in FY 1973. In addition, the appropriation language states that fees collected will be returned to the appropriation and the National Health Service Corps will utilize these fees to support the program.

Question. How are revenues generated by National Health Service Corps professionals being used?

Answer. The Corps has two accounting options that are currently being used to recover reasonable costs from fees generated as required under P.L. 91–623.

Under Option No. 1 the applicant and the Corps each receive a portion of the fees generated that is proportional to the percentage contribution of each. For example: If the total operating expense for a particular quarter (3 months) to the Corps is $6,000.00 and the Community (applicant) expenses for this same period total $4,000.00 then the Corps would receive 6/10 or 60% of all fees generated and the applicant would receive 4/10 or 40%.

Under Option No. 2 the applicant agrees to reimburse the Corps for actual National Health Service Corps costs or expenses during the accounting period.

The revenues generated and distributed under either Option are subject to the following:

All funds, in excess of reimbursements and other costs, that are generated by the community are to be used for the betterment of health services in the community and not for private gain. At the end of each year of operation, a plan for the utilization of such funds if they exist must be submitted to the Regional Health Director. This requirement is clearly stated in Section XII of each National Health Service Corps Memorandum of Agreement.

All funds collected by the Corps under either accounting Option must be deposited in the Treasury as miscellaneous receipts at this time; however, the FY 1973 budget request includes appropriation language which, if enacted, would allow these funds to return to the Health Services Delivery appropriations for use by the Corps.

Question. Do these revenues have any effect on program financial obligations?

Answer. The funds collected by the Corps are deposited in the Treasury as miscellaneous receipts and therefore do not directly contribute to program support. However, those funds that are distributed to the applicant under accounting Options No. 1 or 2 are used to directly defray operating expenses. If such funds are in excess of expenses then they are to be used for the betterment of health services in the community.

If such funds as distributed to the applicant are insufficient to cover applicant cost then this would by necessity increase National Health Service Corps financial obligations.

5. MEDICAL SOCIETY REVIEW

Question. How has the legislative requirement for professional society review of National Health Service Corps placements worked in practice?

Answer. Fifty-five professional societies have delayed, denied, or placed conditions upon professional society certification of National Health Service Corps placements. Fourteen of these have been subsequently approved as a result of clarifying questions or concerns of professional groups in subsequent dialogue.

The breakdown by professional groups is as follows: Medical, 24 (7 subsequently approved); dental, 31 (7 subsequently approved).

Question. Is there any need for a change in legislation in this area, such as repeal of this provision or an appeals mechanism?

Answer. There is no question that it is much better to have the local professional society endorse the effort as an original matter. Having the society's support for Corps assignees assures that once National Health Service Corps professionals are out in that community, they will then get the secondary and otherwise critical cooperation they need to pursue their objectives our position is that the best health care will result if we get the concurrence of the local professional groups.

6. FUTURE SUPPLIES OF MANPOWER

Question. Will the NHSC be able to recruit the health professionals it needs in the coming years?

Answer. The answer to that question is currently not known. At the present time we are primarily placing physicians, dentists and nurses in National Health Service Corps approved positions. Given the current number of authorized field positions we expect that all of those positions will be filled by July of 1973. The future depends on the attractiveness of employment in the Federal Government as a health professional.

Question. Do you expect any particular kind of health professional to be difficult to recruit?

Answer. Physicians and dentists can be expected to be most difficult because of their relative shortage and the opportunities available to them in the private sector.

Question. Is it presently possible for the NHSC to pay competitive salaries for fully trained health professionals?

Answer. Salaries are not presently competitive. The Civil Service System pays somewhat higher than the Commissioned Corps but the differential between this and the private sector will make the recruiting job much more difficult.

Question. What effect would the end of the draft have on the program?

Answer. The anticipated end of the physician draft will have an immediate effect in reducing the number of applicants to the Commissioned Corps of the Public Health Service in general and therefore the National Health Service Corps.

Question. What kinds of recruiting activities has the program engaged in? What additional authorities are needed to guarantee adequate manpower supplies?

Answer. For physicians and dentists the majority of our activity has been tied to the Commissioned Corps of the Public Health Service, and until this time we have attracted a sufficient number of applicants under that system. Nurses and allied health manpower have primarily been recruited locally by the communities and the Regional Offices with some national advertising and personal contacts. In conjunction with the HSMHA physician recruiting activities, our program

has been discussed in every medical school this fall. We have also had exhibits at several meetings such as the AMA convention, the NMA convention, the Student American Medical Association, Student National Medical Association, American Nursing Association and others. We have recently made contact with every Department of Family Practice in the country. We are currently jointly engaged in efforts with the Bureau of Health Manpower Education to attract nurse practitioners and physician's assistants out of programs supported by them. Next month there will be an advertisement in every State medical society journal announcing physician positions in the Corps.

The Department is currently in the process of developing a specific plan for meeting its future needs for health professionals, with particular reference to the special problems involved in obtaining physicians and dentists.

As part of this process, the Department is, at the request of the Director, Office of Management and Budget, chairing an interagency committee which includes representatives from the Department of Defense and the Veterans Administration, and the Civil Service Commission to examine the Executive Branch's needs for physicians in the context of overall national needs.

The study encompasses the matters of projected requirements for physician manpower and alternative ways of meeting those requirements, projected levels of supply, and the implications for the Federal and non-Federal sectors of alternative concepts of compensation and other benefits of Federal employment.

The Department anticipates submitting detailed legislative recommendations in connection with the fiscal year 1974 budget.

7. NUMBER OF SCARCITY AREAS

Question. Has the National Health Service Corps notified all the areas in the country that could use manpower supplied under the Program? Using what criteria? How many are there?

Answer. The National Health Service Corps has not identified any particular area as being in need of National Health Service Corps personnel. NHSC, in connection with the American Medical Association have identified some 120 counties currently without physicians. Some 20 of these counties are now being served and it is the intention of the Corps to start providing medical care to some 20 additional counties. At the present time the Community Health Service is developing criteria for identifying areas which could be classified as having critical health manpower shortage.

Question. What has the Program done to support these areas? What should they be required to do?

Answer. The National Health Service Corps has several contractors who are assisting communities, currently without physicians, to develop appropriate applications for obtaining National Health Service Corps personnel. Forty-two counties are receiving such assistance. As for the identification of critical manpower shortage areas, the National Health Service Corps will be looking for assistance to both the CHP (a) and (b) agency as well as the RMP. These sister agencies of the National Health Service Corps within the Health Service and Mental Health Administration will be able to identify those communities in their area which currently have a manpower shortage and develop a priority listing. From this list the National Health Service Corp can identify those most in need and start to provide technical assistance.

Question. How much money and manpower would be required to respond to all of these critical shortages?

Answer. Given the current state of activity regarding shortage area identification which was enumerated above, it is not possible to provide an answer to this question at this time.

8. CONTRACTS

Question. Has the NHSC let contracts? How many? Cost? From what fiscal year? Legislative authority? List the contracts as to purpose, need, cost and product.

Answer. The Corps has a total of 23 contracts and 25 contracts as per the attached list. These contracts obligate a total of $3,504,285.00 funded from FY 72 funds. The legislative authority for the contracts is to be found under Section 329 of the Public Health Service Act (Public Law 91–623, the Emergency Health Personnel Act of 1970) and by Section 203 of the Public Health Service Act (Public Law 92–157, the Comprehensive Health Manpower Training Act of 1971).

The purpose, need, and cost for each contract are contained in the enclosed

material. All 23 are in various stages of completion so that no final products are yet available. However, specific accomplishments to date have been included in the descriptions of each contract.

Overall Program Rationale for Contract Support for the National Health Service Corps

The primary objective of the National Health Service Corps is to provide health care to communities currently having a "critical health manpower shortage." It is the hope of the Corps that the physicians, and other health professionals placed by it, remain in the communities after the Government terminates its support. To meet these objectives, the Corps must prepare both the communities and our assignees.

Most of the National Health Service Corps assignees are new, young professionals having assignments in rural areas of the United States. If these health professionals are to remain in the community, the Corps must provide them with the professional support and assistance that is normally available to health professionals with practices in urban areas. Due to limited manpower resources, the National Health Service Corps has let several contracts which are intended to provide the necessary assistance to both our physicians and the community in the establishment of a medical practice.

As noted above, most of the National Health Service Corps' field stations are located in rural areas. Given this fact, if the Corps is to be able to recruit and retain health professionals, it must:

(a) know what types of health delivery systems have been successful in providing health care in rural areas,

(b) provide the necessary professional coverage during periods of continuing education,

(c) from past experience, evaluate the success of the Corps' matching of physicians and communities,

(d) provide the orientation and training to facilitate their smooth integration into the communities with differing cultural backgrounds and unique patterns of health care,

(e) establish effective management and problem oriented mechanisms to insure that there is a financial and fiscally sound base to all projects to maintain self-sufficiency following termination of assignment,

(f) establish an effective mechanism for recruiting health professionals, especially physicians with the impending termination of the draft, and

(g) provide necessary technical support to assist physicianless counties to receive NHSC assignees.

The purpose of the contractual arrangements were for supporting our assignees and their projects in the delivery of health care. It is hoped that with such support our assignment will blossom into viable, self-sustaining community projects.

A detailed justification of the 23 contracts follows.

Problem-Oriented Management Development

Contract No. 110–72–423, ($738,900)

RATIONALE

Because the ultimate objective of the Corps is not only to place young professionals in communities, but to have them remain in that community after their tour of duty with the Corps, it is incumbent on the Corps to provide for an orderly and mutually satisfying experience in the establishment of the practice as well as the community relationship. Most of the assignees have had no experience in their own practice; they know very little about accounting, medical records, space arrangements and equipment. An unpleasant beginning in any of these areas could result in a decision not to continue as a private practitioner. On the other hand, to be able to draw upon a proven body of knowledge in this area is of inestimable value, and may be a strong factor in a favorable decision by the assignee.

Accordingly, on July 1, 1972, a contract was negotiated with Family Health Care, Inc., 1150 Connecticut Avenue, N.W., Washington, D.C. 20036, to provide "Problem Oriented" management development and training in Problem Oriented

Practice at NHSC Field Stations. Under the terms of this contract, Family Health Care, Inc. will provide on-site analysis, technical assistance, and training as required to establish a viable practice management structure for each NHSC project. The complete scope of work to be accomplished under this agreement includes a management analysis at all operational Field Stations, to be followed by technical assistance to correct any deficiencies identified. Also FHC will provide specialized training in Problem Oriented Practice to selected NHSC professional assignee's from 20 separate stations. Following this specialized training at the Cross and Bjorn Clinic, Hampden Highlands, Maine, on-site training will be given by the contractor to all personnel at the NHSC Field Stations represented.

In addition to the management analysis and continuing technical assistance, the work plan calls for FHC, Inc. to develop a NHSC Field Operations Manual which will provide policy and procedure guidelines to all NHSC Field assignees.

ACCOMPLISHMENTS

Specific services to be provided under this contract include the following:

Service to be provided	Number	Due date	Progress
Interim field operations manual	250	Aug. 31, 1972	Inhouse review still in process.
Updated field operations manual	250	Dec. 31, 1972	
Final field operations manual	250	June 30, 1973	
On-site management analysis at NHSC field stations.	120 (estimated).	Oct. 30, 1972	On schedule—66 scheduled, 13 completed.
On-site technical assistance in practice management.	84, (estimated).	June 30, 1973	On schedule—some crisis assistance already provided at time of site analysis visit.
Specialized training in existing problem-oriented practice setting.	20	Nov. 30, 1972	On schedule—Trainees Selected-Classes scheduled 1st session October 5, 6, 7.
On-site problem oriented practice training of all staff at selected NHSC field stations.	20	June 30, 1972	On schedule sites have been selected by RHD.
Management analysis reports	5 copies	Within 2 weeks of site visit.	On Schedule—13 reports received.
Management assistance reports	do	do	On schedule.
Monthly progress reports	10 copies	By 10th of following month.	On Schedule—Reports for July and August received.
Quarterly progress reports	do	Quarterly	
Final report	do	End of contract	

Health Care Services to Physicianless Counties

(HSM 110–72–415; HSM 110–72–417; HSM 110–72–418; HSM 110–72–419); HSM 110–72–298)

RATIONALE

The National Health Service Corps has been given the mandate to provide health care services to those counties which do not have the services of a resident physician. The specific language in the legislation is as follows:

> Sec. 203. Section 329(a) of the Public Health Service Act is amended by adding to the end thereof the following: "The Secretary shall use his best efforts to provide to each county certified to him to be without the services of a physician physically residing within such county, at least one physician in the PHS, except for counties so sparsely populated as not to require such a physician. Such physicians shall be assigned so that each county shall have a physician within one year from the date of enactment of this sentence. Within one year from the date of enactment of this sentence, the Secretary shall report to the Congress with respect to his implementation of this section."

A report is due November 1972. Recognizing the limitations of time and staff availability, requests for proposals were developed under the title: "NHSC Manpower Planning for Doctorless Communities, Mountain States, North Central Plain States and Rural South States."

The following contracts have been let:

	Number of physicianless counties	Amount
North Dakota State Department of Health, Division of Health Planning for Physicianless Counties in North Dakota.[1]	6	$26,516 (HSM 110-72-41).
Washington State Medical Education and Research Foundation, for physicianless counties in Idaho and Montana.[1]	Idaho, 3; Montana, 9.	$35,420 (HSM 110-72-41).
Nebraska Comprehensive Health Planning Agency, for physicianless counties in Nebraska.	13	$49,054 (HSM 110-72-298).
University of Virginia, for physicianless counties in the rural South [2]	3	$69,427 (HSM 110-72-418).
Kirschner Associates, for physicianless counties in the rural South (to include Texas).[2]	15	$122,633 (HSM 110-72-419)

[1] This is 1 contract for a total of $61,936 for which the NHSC has 2 contractors.
[2] This is 1 contract for a total of $192,060 for which the NHSC has 2 contractors.

ACCOMPLISHMENTS TO DATE

Kirschner Associates, working with Regional Offices, State Comprehensive Health Planning agencies, Regional Medical Programs, and State and National Medical Societies, and with their own sources of data have identified 15 counties for the activities of the contract.

In accordance with the contract, Kirschner will work with health planning agencies, medical societies, and others to undertake appropriate health care planning on a suitable geographic and resource basis. The first report under this contract was received October 1.

UNIVERSITY OF VIRGINIA

The University of Virginia has worked out arrangements with Kirschner Associates in order not to duplicate efforts with physicianless counties. The University of Virginia will work largely in Georgia and other states of the rural south not being covered by the Kirschner contract. Implicit in this contract is the strategy of involving planning agencies, medical societies, and other groups so that simple health care systems appropriate to the needs of physicianless counties will be designed, maintained and supported at the conclusion of the contract.

Output from the contract will be specific health care and applications for NHSC personnel to meet the health needs of county residents.

WASHINGTON STATE MEDICAL ASSOCIATION

This contract will cover the states of Montana and Idaho. Preliminary assessment reveals there are three physicianless counties in Idaho and seven in Montana. Six physicianless counties had initially been identified by the contractor and a seventh subsequently identified. The contractor has indicated that an eighth Montana County will be considered as potentially physicianless because its only physician is 74.

To date, the contractor has made introductory contacts with the medical association of both states, explaining the contract and their function. Both states, especially Idaho, have rather conservative medical associations, especially regarding any Federal programs, and the contractor is proceeding with considerable care, keeping the associations informed of every step of procedure. Preliminary site assessments have been completed in most of the physicianless counties in Montana. The majority of these counties are too sparsely populated to support an independent viable health care delivery system. However, it appears that several potential systems could be developed for the placement of Corps personnel. As of October 1, no site assessments have been accomplished in Idaho. In depth discussions with the Idaho State Medical Association were scheduled for late September.

NORTH DAKOTA STATE DEPARTMENT OF HEALTH—DIVISION OF HEALTH PLANNING

There are six physicianless counties in North Dakota. To date, further details of the scope of work have been discussed with the contractor; he has assessed the health care delivery needs in general terms, and they have proposed, tenta-

tively, that three counties could be served by the development of delivery capability from a medical center located in a fourth county which would have outreach and satellite clinic(s) in two of the physicianless counties. Another physicianless county could be served by increasing the delivery capability in a neighboring county with the establishment of a satellite clinic in the physicianless county. A fifth physicianless county appears to have fairly easy access to two medical centers. The last physicianless county is predominantly populated by on-reservation Indians, served by IHS. The health needs of the remainder of the population will be investigated in depth during the period of this contract.

The contractor has contacted several of the basic groups involved in the development of NHSC applications and has informed them of the Corps programs. These groups and communities are reviewing their own health care needs to decide themselves whether or not they are interested in applying for Corps assistance. The contractor has offered and identified other resources for technical assistance. They will also identify alternatives, other than the Corps, for meeting health care needs.

STATE OF NEBRASKA—CHP AGENCY

This contract will develop health care plans for a significant number of physicianless counties in the North Central Plains. The State of Nebraska has limited itself to one area, the State of Nebraska, but within that area has expanded its scope of work to include health care plans for scarcity areas other than physicianless counties.

The contract is to be performed in three phases:

Phase I—Selection and identification, based on systematic analysis of the scarcity areas, of the counties to be selected for possible NHSC placement. This phase was completed August 31, 1972, and a progress report has been received.

Phase II—Planning and implementation of an organized effort to develop acceptable NHSC applications in these scarcity areas. This phase is now under way and will be completed by December 31, 1972. The progress report received contains a thorough explanation of the methodology for completing this phase of the contract.

Phase III—Transfer of responsibility to local organized entities who will be charged with the ongoing responsibility for health care planning and project management in coordination with various state-wide health organizations. This phase will terminate the contract on June 30, 1973.

The contractor's Progress Report identifies 24 counties in Nebraska as being scarcity areas, and includes description of the methodology for defining scarcity areas and for, implementing phase two of the contract.

RURAL HEALTH CARE MODELS

(Contract #110–72–279 ($41,409))

RATIONALE

In making assignments of health manpower to medically underserved areas, the NHSC attempts to make placements in such a manner as to insure that, to a significant degree the manpower placed will remain in the community as a private provider after termination of Federal Service. To help accomplish this objective in rural communities, the NHSC has sought to identify a range of rural health care models which represent viable options for the placement of personnel. The purpose of this contract is to develop a consultative tool in counseling rural communities applying to the Corps for health personnel.

Available information on the problem of why health personnel leave medically underserved areas or do not wish to settle there suggest a variety of reasons such as, isolation from peer relationships, isolation from the opportunity for continuing education and lack of interrelations with varying kinds and types of health manpower, including paramedical personnel. In order to deal effectively with such problems, the Corps is attempting to bring together tested models of rural health care delivery systems into a program tool for rural communities counseling.

In order to benefit from the experience and prevent any duplication of efforts, of other Federal and private institutions in building rural health care systems, an advisory committee composed of 21 members has been named.

Conference on the Status of Dental Health in Black Communities and Conference on the Status of Health in Black Communities—NMA and NDA

(NDA, HSM 110–72–373 ($66,000) ; NMA, HSM 110–72–108 ($57,526))

RATIONALE

The NHSC has been asked to provide medical manpower to medically underserved areas. Such communities appear to be mainly in remote rural areas and inner city ghettoes where there are large concentrations of Black people. NHSC application guidelines require certifications from appropriate medical societies, linkages to providers, and efforts of communities involvement and support. It seemed, therefore, desirable for the Corps to focus attention through a conference that would permit the status of health in the Nation's Black communities both medical and dental to be highlighted through a discussion by knowledgeable personnel of the health programming needs of the Black community as they relate to the NHSC and other Federal programs.

PROGRESS

A conference on the health care needs of the Black community was held in Nashville, Tennessee, on November 10–11, 1971. Approximately 600 individual representatives, providers and consumers, both public and private, and voluntary health organizations participated in the conference. A final report together with recommendations has been received.

A conference was held in New Orleans, Louisiana, on dental health needs of the Black Community on July 28, 29, 30. Approximately 200 health professionals and consumers of health care representating both public and private sectors, attended the conference. A progress report representing the health conference has been received.

NHSC Pre-Service Orientation and Training and In-Service Education and Field Support

(Contract No. HSM 110–72–283 ($1,427,530) ; Contractor: National Training Lab, Inc.)

RATIONALE

The intent of the contract is to provide orientation and training for National Health Service Corps professionals and community applicants. It was felt that if the goal of the Corps—to affect the maldistribution of health manpower—was to be achieved, some attempt must be made to train professionals how to function effectively in manpower shortage areas and help communities look at those factors which might hinder the continuity of health manpower in their community. Some of the specific areas that were considered important were as follows:

1. Developing a working relationship between the assignees and the community.
2. Develop a plan for continuity of manpower in a community, looking at what a community might do if National Health Service Corps could no longer support them.
3. Facilitating an effective professional team operation that will provide for maximum utilization of manpower and maximum professional satisfaction.
4. Developing a plan for continuing education that would tap local resources and help to obviate professional isolation.

It was felt that if these objectives could be achieved, it would maximise the possibility of some professionals remaining in the community or help a community look at why it cannot keep professionals and what conditions might it change.

The major components of the contract include:

1. Pre-service component before assignment.
2. On-site consultation to work with some of these issues, involving all parts of the system in which the assignees will be functioning.
3. In-service education component to provide an opportunity for assignees to get together for sessions around topics which they have found a need for, to work more effectively in their communities.

ACCOMPLISHMENTS TO DATE

The pre-service component of the contract was conducted in regional cities in July 1972 with the assignment of almost 200 professionals. Following this, because the Corps has rapidly decentralized, we have developed regional training plans in each of the ten regions in conjunction with the National Health Service Corps Program Director in that region. The regions are now in the process of making initial visits to each of the sites to involve the assignees and communities in planning for their on-site work plus the in-service conferences.

PHYSICIAN COVERAGE FOR NATIONAL HEALTH SERVICE CORPS HEALTH FACILITIES

(Contract No. HSM 110–72–349 ($76,800); Contractor: American Medical Association)

RATIONALE

This contract was awarded on the basis of an unsolicited proposal from the American Medical Association entitled "Project U.S.A.". In this project the American Medical Association will attempt to recruit physicians out of the private sector to fill in for periods of time when National Health Service Corps physicians will be away from their communities both for periods of annual leave and any extended continuing medical education. The rationale for awarding this contract is that since our communities are in manpower shortage areas, it will be just as difficult to find replacements as it was to find the assigned manpower itself. This proposal was analogous to a project which the American Medical Association has already carried out in providing voluntary civilian physicians for short-term assignments in Vietnam.

ACCOMPLISHMENTS TO DATE

The American Medical Association has hired a coordinator for this project. They are in the process of developing forms whereby they will be informed of the expected dates when coverage will be required in each community. They are at the same time developing recruiting plans whereby they will identify physicians who will provide such coverage. Although it is out of the Scope of Work, we expect that some of the physicians that they identify for short-term coverage may be successfully recruited into the program for full-time assignments.

RECRUITMENT OF A PHYSICIAN AND NURSE RECRUITING PROGRAM FOR THE NATIONAL HEALTH SERVICE CORPS

(Contract No. HSM 110–72–399 ($33,000); Contractor: Arthur Young & Co.)

RATIONALE

As the National Health Service Corps expands its activities and as the physician draft phases out, the National Health Service Corps will have to engage in an extensive program of recruiting health professionals from the private sector to serve in the health manpower shortage communities that we approve. Because of our reliance to the present time on the Commissioned Corps of the U.S. Public Health Service as a recruiting mechanism, we have little experience in such activity in the private sector. The Contractor will, therefore, provide us technical expertise in the planning of our recruitment program. Specifically, he will ascertain each of the sub-populations of physicians and nurses in the private sector that are felt to be potentially recruitable into the National Health Service Corps. He will identify any attitudinal and motivational hypotheses or considerations in this group that affect potential service in the National Health Service Corps. He will attempt to specifically identify the incentives that will have to be provided in order to attract such people into the Corps and to keep them for a reasonable period of time. Finally, he will design an operational recruitment program for the National Health Service Corps that would meet these constraints.

ACCOMPLISHMENTS TO DATE

The first three months of this contract have been spent in determining the demographic characteristics of the target sub-populations of physicians and nurses. That report will be presented to the National Health Service Corps on Friday, October 6. Following that, the Contractor will begin work on identifying the key incentives and on designing the specific operational recruitment plans.

DEVELOPMENT OF A METHODOLOGY FOR PREDICTING SUCCESSFUL MATCHES OF HEALTH PROFESSIONALS WITH NATIONAL HEALTH SERVICE CORPS COMMUNITIES

(Contract No. HSM 110–72–412 ($60,700); Contractor: Human Sciences Research, Inc.

RATIONALE

One of the basic goals of the National Health Service Corps is to match health professionals with underserved communities in such a way that they will provide optimum service while they are there and will stay in that community for a maximum period of time. Although there are many subjective approaches to the matching of individuals to communities, there is very little known that is directly applicable to the National Health Service Corps in carrying out this specific function, i.e., matching health professional to health manpower shortage areas. Therefore, the purpose of this contract study is to determine both by a summary of all existing knowledge and by independent investigation, those factors that are expected to predict a successful match between such personnel and such communities. Once, having identified those predictive factors, the Contractor will develop both data collecting instruments for obtaining the necessary information from personnel and communities and develop analytical techniques by which such predictions can be made by us in the matching process.

ACCOMPLISHMENTS TO DATE

The contract was effective June 30, 1972. As of October 1 the Contractor has completed the first phase of the operation and has submitted a report describing their literature search as to what is currently known about the problem. They are now beginning the investigative phase where, based on the information they developed, they will be looking themselves into successful practices in shortage areas and will come up with a list of predictive factors. The remainder of their time will be spent during the first six months of 1973 in developing both the data collecting instruments and the analytical techniques for making such matches.

DEVELOPMENT OF A CONCEPTUAL MODEL FOR A MANAGEMENT AND CONTROL SYSTEM FOR NHSC

(Contract No. 110–72–295 ($24,370))

RATIONALE

The purpose of this contract is to provide to the Director of NHSC the design of a system which will facilitate his control, monitoring, evaluation and analysis of the activities and operations of NHSC.

ACCOMPLISHMENTS TO DATE

The contractor has inventoried the informational needs of the various Division of the Corps. A "Tally Sheet" has been developed for use by NHSC projects which records and reports required information needed by Central and Regional Office staff for effective management control. The "Tally Sheet" is currently undergoing a limited field trial and the contractor will report on Friday, October 6, the results, progress to date, and work in process for completion of the contract. A final report will be made on November 1.

Outreach Services for Seattle Indian Health Board

(Contract No. HSM-110-72-392 ($90,240))

RATIONALE

Realizing the extensive health care needs of the urban Indian Group and knowing that persons other than the Indian population benefit from the services provided in the PHS Hospital Clinic in Seattle, HSMHA is attempting, through outreach services, to provide care to an even greater number of individuals in the Seattle area.

The contract calls for the SIHB to serve as a catalyst for developing and establishing followup patient referrals to the area hospital and outpatient clinic services and to assist the Indian population toward greater utilization of services that are available. The project will serve to identify gaps in resources and to open these areas to the health needs of the Seattle Indian Health Board Clinic beneficiaries.

The major activities to take place from the new Outreach office in the new Indian Center will be health education, preventive health services, referrals, counseling and outreach to other programs.

ACCOMPLISHMENTS TO DATE

Although prolonged negotiations have retarded the initiation of services, when advanced funds were made available to SIHB in August, recruitment and hiring began. Services are now being provided, but a tabulation of types and volumes is not available.

SNMA Vacation Preceptorship Program

(Contract No. HSM 110-72-424 ($149,300) Contractor: Student National Medical Association)

RATIONALE

This contract was awarded in response to an unsolicited proposal from the Student National Medical Association for support of their ongoing Vacation Preceptorship Program. The purpose of their program is to enable minority medical students to spend periods of elective time in the practices of National Medical Association physicians, in order to get a broader exposure to what actual office practice is all about. We saw the additional support of this program to be consistent with our goal of increasing the number of minority physicians to serve patients in health manpower shortage areas. A condition of our support was that any student who enrolled in the program using National Health Service Corps funds must spend his preceptorship with a physician who is giving primary care in health manpower shortage areas similar to National Health Service Corps communities. We see this as a long range, broad support activity of developing minority professionals. We do, however, have some expectations that many of the students will be attracted to the National Health Service Corps program because of their participation in the preceptorship.

ACCOMPLISHMENTS TO DATE

This is a two-year support effort. The majority of the preceptorships take place during the summer months when most medical students have elective time. Approximately 30 additional students were enrolled in their project this summer as a result of National Health Service Corps support. A progress report on the first three months' activity is expected within a week.

Determining All of the Fiscal Policies and Procedures Necessary for Complying with Provisions of Public Law 91–623

(Contract No. HSM 110–72–52 ($23,300) Contractor: Mr. Frank Chinn)

RATIONALE

This contract was awarded in order to develop the fiscal policies and procedures necessary to comply with the provisions of P.L. 91–623, the Emergency Health Personnel Act of 1970, and to provide fiscal advice to NHSC "site visit" teams.

ACCOMPLISHMENTS TO DATE

The accounting systems have been developed and manuals prepared for use of communities.

Planning and Conducting a 2- to 3-Day Symposium on Essential Topics in Health Care

(Contract No. HSM 110–72–117 ($10,000 partial funding) Contractor: Institute for the Study of Health and Society)

RATIONALE

This contract was awarded to promote communication among the Nation's medical house staff and to coordinate the development of a set of health policy issues of interest to the house staff. These doctors constitute a manpower pool from which the NHSC secures its assignees to accomplish its mission.

ACCOMPLISHMENTS TO DATE

Final report from the Institute has been submitted.

Planning and Evaluation Assistance to the Office of P. P. & E.

(Contract No. HSM 110–72–369 ($25,000); Contractor: MARCO Systems, Inc.)

RATIONALE

NHSC, among other programs, contributed to this contract as it had beneficial output for overall HSMHA planning purposes. Among these was the development of innovative uses of health and health-related manpower which would assist the NHSC in the execution of its mission.

ACCOMPLISHMENTS TO DATE

Reports will be submitted from time to time, with a final report due on June 30, 1974.

Planning Project for Health Service Integration With Williams Community Education Center

(Contract No. HSM 110–72–278 ($35,000); Contractor: Flint Board of Education)

RATIONALE

This contract was awarded to develop a detailed design for the integration of health services, health education and health maintenance activity in the poverty area around the Williams Community Education Center in Flint, Michigan. It is to include an investigation of the potential for utilization of students in the health sciences.

ACCOMPLISHMENTS TO DATE

The first report is due June 30, 1973.

PHYSICIANS IN THE 1970'S CONFERENCE ON UTILIZATION OF HEALTH MANPOWER AND HEALTH FACILITIES

(Contract No: HSM 110–72–249 ($15,000 partial funding); Contractor: Roy Littlejohn Associates, Inc.)

RATIONALE

This contract was for partial support of a conference sponsored by the Student National Medical Association. The conference included in-depth panel discussions on the maldistribution of health professionals, on planning health facilities to meet patient needs and community needs, and on the team concept in health care delivery.

ACCOMPLISHMENTS TO DATE

The Student National Medical Association has submitted a report on the above.

SAMA MEDICAL EDUCATION COMMUNITY ORIENTATION PROJECT

(Contract No: HSM 110–72–388 ($199,600); Contractor: Student American Medical Association)

RATIONALE

The goals of this project will be to encourage medical and other science students to practice in community settings, to involve community based practitioners in the education of health science students, to expose students to existing health resources and encourage them to develop more effective methods of providing health care and preventing disease.

ACCOMPLISHMENTS TO DATE

Began June 28, 1972, to run 3 years; periodic reports and evaluation reports to be submitted.

SPONSORING AN INFORMATION INTERCHANGE CONFERENCE

(Contract No: HSM 110–72–253 ($36,025); Contractor: Curber Associates)

PLAN AND CONDUCT A 3 DAY PROGRAM FOR HSMHA MANAGEMENT PERSONNEL

(Contract No: HSM 110–71–59; Contractor: Curber Associates)

RATIONALE

From time to time, various HS programs contribute to the support of projects which benefit all of HSMHA. Such indirect benefits accrued to the NHSC through contracts such as this which provided for a series of organizational development programs for HSMHA management and supervisory personnel.

ACCOMPLISHMENT TO DATE

Increased productivity due to promoting internal change by improvement of supervisory skills.

THE CITY AS A UNIVERSITY PROJECT

(Contract No: HSM 110–72–290 ($9,735); Contractor: Harvard University)

RATIONALE

Develop, in the Boston area, a program whereby students (including Graduates, Medical Students, etc.) might engage in a study of problems in the health field. The purpose of this project is to recruit and place students in public health

experiences which include exposure to various types of problems encountered in health care delivery and evaluation and thereby interest such students in continuing to work in the field.

ACCOMPLISHMENT TO DATE

A report is due at the end of December 1972.

Mr. Rogers. The committee has had brought to its attention by Congressman Adams a concern of his regarding these six contracts. Are you aware of that?

Dr. Zapp. Yes, sir.

Mr. Rogers. The six contracts which were funded under section 329?

Dr. Zapp. Yes. They were funded under section 329, Mr. Chairman.

Mr. Rogers. What authority in the law permits that?

Dr. Wilson. Those are covered and we would be happy to supply this in detail for the record.

Mr. Rogers. Yes.

Dr. Wilson. Why don't we do it for the record, then?

Mr. Rogers. Could you just give me a pointing out of what is the position of the law that permits this?

Dr. Wilson. In five of the specific contracts under discussion, the issue being addressed was the mandate that we had in the amendment to attack the problem of the physicianless counties, that is, we were directed at a later date to deal with that. This was an attempt to deal with that problem. One of the large contracts that is under discussion, was the contract that was allowing us to deal with the issue of the quality of care that would be delivered because we have here sort of a new phenomenon, we don't have the protections of quality of care that we have, for instance, in an established medical group or in a hospital or another group.

So what we were attempting to do there is to set up a model patient care record, something that would be useful to the young professional at a later date in his own practice. But we would make sure that we had a chance either directly or indirectly to assure that quality care is being given.

Mr. Rogers. Yes, but we would like the actual written authority of the law because I think the committee staff is looking for this and they don't feel that there is any.

Dr. Zapp. Mr. Chairman, we would be glad to supply you with an explanation of the various contracts that were given and also our interpretation of the legal authority that we would have to use.

(See item No. 8. Contracts, eighth question and answer of "Answers to questions submitted by subcommittee," p. 79, this hearing.)

Mr. Rogers. You know what disturbs me most, here we have the Public Health Service giving care. Now they have to have records in those hospitals and the areas we give care to and yet we still have to put $1 million in planning all this and go through it again, when we are already using that money to provide services.

Dr. Wilson. Now, this is not planning in the sense, I believe, the Representative understood it and as he placed it in the record. This is the matter of establishing a quality type surveillance method that would be useful both onsite and for us and for——

Mr. Rogers. Well, I understand that this is for recordkeeping.

Dr. Wilson. That is correct, and it is ambulatory medical care recordkeeping which is sort of an unchartered field in the whole profes-

sion at the moment. In the hospitals we didn't have that problem because it was attached to a hospital recordkeeping system. There is very little has been done across the country on free standing ambulatory record care systems and we found ourselves involved in a quality problem without the kind of system we could use to discharge our responsibility.

Mr. Rogers. I would have thought with our clinics, our public health clinics, we would have had considerable experience in that recordkeeping. I am talking about the clinics not affiliated anywhere near a hospital. Is that not so?

Dr. Wilson. Not for this kind of a care system, no.

Mr. Rogers. Because it just seems to me we spend millions of dollars studying the same thing we have already studied or have experienced rather than using the money to get personnel out doing the job. We know what we have to do. We have to give some care. I know this is over-simplification but surely $1 million to study how to keep a record—well, I know it is not all that simple. I know it is something like $140,000 but——

Dr. Wilson. It is not to study how to keep a record. It is to establish a recordkeeping system. I think there is a difference.

Mr. Carter. On that, Mr. Chairman, many of the clinics and group practices throughout the country have had to employ special personnel for recordkeeping and are affiliated with computer programs that fix their bills each month, which is extremely helpful.

Mr. Rogers. Yes. And I would have thought, you know, this had been done so many times that we would be done with it.

Dr. Zapp. I think the committee's question is well taken and I hope that the rationale and the justification for the use of this authority for this purpose, Mr. Chairman, will be adequate. We will submit it as soon as possible.

Mr. Rogers. The committee would like to know that. As I said, we have other questions but our time is running late. And if there are no other questions right now—well, are there other questions? If not, we are grateful for your being here and the committee will expect to get the answers.

Dr. Zapp. Yes.

Mr. Rogers. Our next witness is Mr. O. William Moody, Jr., administrator, Maritime Trades Department, AFL–CIO.

Mr. Moody, we appreciate your being here.

STATEMENT OF O. WILLIAM MOODY, ADMINISTRATOR, AFL–CIO MARITIME TRADES DEPARTMENT, ACCOMPANIED BY BOB VAHEY, RESEARCH DEPARTMENT, TRANSPORTATION INSTITUTE; AND BERT GOTTLIEB, DIRECTOR, RESEARCH DEPARTMENT, TRANSPORTATION INSTITUTE

Mr. Moody. Mr. Chairman, we deeply appreciate your giving us this time. In recognition of the lateness of the hour, we will try to move right along with our statement.

Mr. Rogers. We will make your full statement a part of the record. If you desire to add comments, you may do so.

Would you like to certify your colleagues?

Mr. Moody. I am accompanied by Mr. Bob Vahey of the research department of the Transportation Institute, and Mr. Bert Gottlieb, the director of research for that organization, which is a management-endowed organization which shares our interest in the health care of seamen and other maritime workers.

Mr. Rogers. Welcome.

Mr. Moody. The committee well knows and has heard us discuss on a number of occasions our interest in the Public Health Service hospitals. I would like to again express our appreciation to the committee for its perseverance and determination under your leadership. Chairman Rogers, in preserving the remaining hospitals of the Public Health Service Hospital System because I think, without your interest, we wouldn't need to be addressing ourselves to this subject any longer.

I would like to say, with respect to H.R. 16755, in general, we support this legislation. We think it is good legislation, we think it is legislation that is certainly needed in today's medical care problems. Specifically, we have a concern with how this legislation relates to the Public Health Service Hospital System and we hope that the effect of this legislation will be to state legislatively that the Department of Health, Education, and Welfare does not have the unilateral right to disband the Public Health Service Hospital System and, for that reason, we believe that section 3 not only is necessary but needs clarification and strengthening. To that extent, we disagree with the previous witness from the Department. We believe that section is needed for the very same reasons that they oppose it because, on the basis of past performance, we don't take a great deal of confidence in their assurances that they won't unilaterally discontinue these services that we think are so vitally necessary. We think that the clarification comes in the area of making it absolutely clear to the local communities that this legislation is not intended to encourage them to phase out the hospitals.

We think this legislation should be written so that somebody from the HEW bureaucracy can't go down into the local communities and give the impression that Congress now is encouraging them to phase out the hospitals. We think this is necessary to be made clear. We believe this is needed on the basis of our experience at the beginning of the discussion of local control. If you will pardon the personal reference, I had the experience when I went to New Orleans, La., to testify—HEW didn't call them hearings; they called them "community discussions"—but I found to my great surprise and shock when I arrived in the New Orleans community, that I know very well since I lived there for a good many years, that there was a general feeling in the community that Congress was no longer going to fund the hospital, that they had to find a way to take over that hospital or it was going to be closed.

So we would like to suggest that this possibility of confusion could be avoided if we amended, or if the preamble of section 3(a) could be amended to read—and I would like to read that—that:

> It is the intent of Congress that the PHS System be maintained as an integral part of the many innovative health programs, including the Health Manpower Act now being developed to serve the citizens of this Nation. Therefore, the Secretary shall not close or transfer control,

and so forth.

Now, we think that section 3(b) also guarantees that should a Public Health Service hospital facility be transferred, the beneficiaries using the hospital would continue to receive the same level of care. But we are concerned that there might be some vagueness in the language of this section and we hope that it would be made crystal clear that the secondary beneficiaries would also continue to receive the same level of care—and I am speaking of such dependents as the Department of Defense dependents and retirees who have no other Federal facility to which to go and if they were cut off from this source of care would have to rely on the Champus program.

The bill places considerable emphasis on the approval of any transfer porposal by A and B Health Planning Agencies. We think this is vital and important, but there is language in the existing law for 314 agencies that require health consumer groups to be included on the State planning agencies. There is no such requirement for the B agencies, the local B agencies and we would like to see the legislation made clear that the representatives of the primary and secondary beneficiaries who have a first stake in the Public Health Service hospitals be fully represented on both the A and B agencies.

Our statement deals also with the opportunity for expanding the role of the Public Health Service hospitals, the kind of thing that you have heard much testimony on before; but there is an opportunity to do some real innovative work in the delivery of health care and with these clarifications and further tightening of the legislation, why we would give it our all-out support.

(Mr. Moody's prepared statement follows:)

STATEMENT OF O. WILLIAM MOODY, ADMINISTRATOR, AFL–CIO MARITIME TRADES DEPARTMENT

My name is O. William Moody. I am the Administrator of the AFL–CIO Maritime Trades Department. I also represent the Seafarers International Union of North America. Both the Maritime Trades Department and the Seafarers International Union support the passage of H.R. 16755.

This far-sighted bill would have an important effect on this nation's health care delivery system. It would tremendously improve efforts regarding the delivery of health care to areas lacking adequate medical coverage. These are goals long supported by the AFL–CIO Maritime Trades Department.

We also are in agreement with those sections of the bill that would significantly strengthen the safeguards against the Department of Health, Education, and Welfare either closing or transferring a Public Health hospital and clinic.

There are just a few important changes however which the Maritime Trades Department feels must be made in the proposed legislation to insure that the bill's intent is carried out in practice. I will detail those changes in this statement.

The AFL–CIO Maritime Trades Department congratulates the Health Subcommittee of the House Interstate and Foreign Commerce Committee and the Subcommittee's chairman, Congressman Paul Rogers, for the strong support they have given in the past to the Public Health Service. Without this strong and unwavering support, it is likely that the Public Health system would have long ago been closed by hostile government bureaucracies opposed to the hospitals and their direct Federal health care role.

The AFL–CIO Maritime Trades Department has a strong concern for the continued operation of the PHS hospitals and clinics. The MTD is made up of 45 international labor unions, who together represent eight million American workers, many thousands of whom are primary beneficiaries of the PHS system.

These men and women have had long personal contacts with the fine health care facilities and staffs of the PHS facilities. In many cases, these workers owe their lives to the skill and dedication of the doctors and staffs of the PHS hospitals.

Thus, the Martime Trades Department has a deep interest in the deliberations of Congress concerning the Public Health Service. In the past ten years, this matter has come before the Congress at least four times. In particular, over the past twenty months, the Maritime Trades Department has been fighting a fierce campaign against the attempts by the Department of Health, Education and Welfare to close there fine health care facilities.

We are sure every member of Congress is aware of the deceit and trickery practiced by the Department of HEW in its many attempts to close the PHS hospitals. Even though this Congress in Concurrent Resolution Six, made clear its intent that the PHS system must be maintained, the Department of HEW has still continuously sought to close these facilities.

The latest example of HEW's intent occurred last month at the PHS clinic in St. Louis, Missouri, where it was discovered that the Department had suddenly closed the PHS pharmacy there and had reduced the doctor staff to one part-time physician. The Department of HEW did this with no prior notice to the community and at a facility where there was a large and growing patient load.

Fortunately, Mrs. Leonor K. Sullivan (D-Mo.) herself a long champion of the Public Health Service, interceded in behalf of the clinic. Her strong protest to the Department prevented further attrition at St. Louis and returned the doctor staff to full strength. Yet even her intervention was not enough to prevent the loss of a full-time, trained pharmacist.

Events such as these make clear the callous attitude of the Department of HEW concerning the Public Health Service. In the face of a United States Controller General's decision that the Service be maintained, in the face of the unanimous support of Congress, and even in the face of the opposition of local communities, as in Seattle and San Francisco, the Department continues to push for the closure of the PHS hospitals and clinics.

In the face of this continued intransigence by the Department of HEW against the wishes of Congress, the Maritime Trades Department is heartened by the introduction of this new bill.

HR 16755 will provide long needed guarantees that will prevent the Department of HEW from closing or transferring any hospital without the approval of the Congress, of local communities, of the beneficiaries and other groups who are concerned about the fate of the Public Health Service.

In discussing this bill, the AFL–CIO Maritime Trades Department wishes to clarify its philosophy on the role of the Public Health Service. We in the Maritime Trades Department are committed to the maintenance of quality and priority medical care for seamen. This is the ideal which we have long strived to maintain and it is for this reason we have fought so hard in the past to preserve the PHS hospitals, which to us have signified the world's best medical care.

Yet, too often in the past, most recently in Detroit, Savannah, Chicago, and Memphis, the members of the MTD's affiliated unions have seen PHS hospitals close and no other hospital services of the same quality replace them. Each time the Department of Health, Education and Welfare has made promises that seamen would be served by local hospitals. But never have these promises been fulfilled.

Thus, the Maritime Trades Department has been forced by the Department of HEW to take a stand against any further hospital closures. The MTD's policy became one of fighting any HEW action until the Department would present a workable plan to provide seamen quality and priority medical care. This is the position we are in today.

While we have waited for a guarantee from HEW, it has deliberately allowed the PHS hospitals to deteriorate. It has starved them of funds, undermined the staff morale and used every type of insidious device to ruin these hospitals. That it has not succeeded so far is a tribute to the loyalty and dedication of the PHS staffs.

The bill we now consider would not alter our position regarding the Department of Health, Education and Welfare. We will continue to oppose its every act against the hospitals.

The primary effect of this bill will be to make it more difficult for the Department of HEW to transfer a hospital. HR 16755 for the first time sets down specific safeguards against a sudden attempt by HEW to close a hospital. It provides additional safeguards against the Department being allowed to accept a deficient or harmful transfer proposal.

Yet, it does not remove the MTD's opposition to the Department of HEW's plans. Until the Department can guarantee the Maritime Trades Department both a better health care plan and assured quality, Priority medical care for seamen, we will never agree to any type or form of PHS facility transfer.

While HR 16755 has the strong support of the Maritime Trades Department, there are some areas of concern about this bill and the future of the Public Health Service facilities which must be reviewed.

THE NEED TO CLARIFY TO THE DEPARTMENT OF HEW THE INTENT OF HR 16755

In the past even when the intent of Congress about the Public Health Service has been crystal clear, the Department of HEW has consistently avoided carrying it out. The main danger that this created was that local communities, who necessarily receive their information about the hospitals from HEW, could be misled into believing the opposite of the true congressional intent.

This could be the case with HR 16755. This bill would for the first time allow the Department of HEW the option of transferring the PHS hospitals and clinics to community hands. Until now the dismantling of the PHS system has been expressly prohibited by the Controller General of the United States and has been opposed by the entire Congress.

The Department of HEW is sure to construe this new authority in HR 16755 as approval to proceed with all of the transfer plans. Instead of telling the communities that transfer is but *one* option, the Department of HEW will signal to the communities that *Congress* has now approved the submission of transfer proposals. The Department would probably do this without telling the communities that the policy set forth in HR 16755 is but a reiteration of previous conditions for transfer, as in Concurrent Resolution Six, and that transfer itself is but one of several alternative policies for the PHS hospitals.

This could be prevented by amending the Preamble of Section 3(a) to read: "It is the intent of Congress that the PHS system be maintained, as an integral part of the many innovative health programs, including the Health Manpower Act, now being developed to serve the citizens of this nation. Therefore, the Secretary may not close or transfer control . . . ."

Thus, Congress would signal its clear intent that nothing in HR 16755 is to be construed as a basis for initiating the closure or transfer of any PHS hospital or clinic.

Section 3(b) also guarantees that should a PHS facility be transferred, the beneficiaries using the hospital would continue to receive the same level of care. Yet this section is vague about whether it would also cover secondary beneficiaries, who may also be using the hospital.

The secondary beneficiaries, such as DOD dependents and retirees often have no other Federal facility to go to, mainly because of the crowding at military hospitals. To deprive them of PHS care would force them to use the Champus program, which requires that they pay a part of the costs.

We strongly urge that this section of HR 16755 be clarified so that it specifically includes not only primary PHS beneficiaries, but also all possible groups of secondary beneficiaries who may be eligible to receive PHS health care.

Only in this manner will this important segment of the Public Health Service's patients be assured that their interests and health care needs will be protected in any transfer proposal.

A further addition to this clause should be a requirement that the Department furnish a "detailed explanation of how such persons (beneficiaries) will be provided such care and treatment after the proposed closing or transfer." This is done for the other sections of Section 3(b) and should also be done in Section 3(b)(1)(B) of HR 16755.

BENEFICIARY REPRESENTATION IN "A" AND "B" AGENCIES

This bill will place a great emphasis on the approval of any transfer proposal by Section 314 (A) and (B) health planning agencies. Thus, it is vital that the persons most affected by a transfer plan, the PHS beneficiaries, have a voice in the "A" and "B" agency approval process of transfer plans.

In this regard, there is language in the existing law for 314(A) agencies that require "health consumer groups" to be included on the state planning agencies. There is no such requirement in the local (B) agency law.

Thus, to insure that Public Health Service beneficiaries and employees have a strong voice in the deliberations on the PHS hospitals, the AFL–CIO Maritime

Trades Department strongly recommends that the language of HR 16755 be amended to include in Section 3, and 4, that representatives of the various primary and secondary beneficiary groups be fully represented on the "A" and "B" health planning agencies, in cities and states where hospitals are located, in order to advise these bodies before any decision can take place concerning the PHS hospitals.

In this way, the interests of the hospitals can be protected. At the same time the beneficiaries, who know best the tricks that HEW will use to try to rid itself of these hospitals, can alert the community to the dangers they face in dealing too quickly with the Department of Health, Education and Welfare.

EXPANDING THE ROLE OF THE PHS HOSPITALS

There are several other vital matters not contained in this bill that should be considered by the Senate Health Subcommittee. They all revolve around the vital task of integrating the work of the National Health Service Corps with the excellent facilities available in the Public Health Service.

Prime among these is an even further expansion of the role of the Public Health Service into new and innovative forms of health services and delivery. Included among these could be a PHS mission as a testing ground for new hospital equipment and hospital administration. The construction of new PHS hospitals could provide the opportunity for innovative and functional hospital designs. And the PHS could even further its pioneering role in new forms of medicine and disease control.

All of these new missions for the PHS hospitals are possible with the existing facilities. Not only would these new missions employ usefully some of the current excess manpower at PHS facilities, but it would also help to get started many health projects that have long been needed, but have lacked a vehicle.

Another area of promise for the hospitals relates to the future growth of the Health Service Corps. If this Corps is to grow, it must depend on the influx of dedicated young professionals to serve the many areas of medical scarcity in the United States. At the same time, these professionals must be recruited in a "no-draft" situation and then retained beyond the initial two-years they first sign up for. Only in this manner can the Health Service Corps be built into the effective medical service that was invisioned by its creators.

To do this will require that the Corps be made an attractive and fulfilling career. One of the most important ways this may be done is to provide these professionals hospital facilities to use for training and research. The PHS hospitals could be successfully integrated into the Health Service Corps and could provide these doctors the impetus they need to turn a two-year term into a public health career.

Also, the PHS hospitals would be excellent for inpatient referrals that would be generated by the growth of clinics under the Health Service Corps set-up.

While HR 16755 starts toward this expanded mission, it does not go far enough. We must look upon this bill as only a stepping stone to greater and more worthwhile projects that will benefit every American. Only in this way can the great potential of the PHS hospitals be realized.

MODERNIZATION TRENDS

The final need, which should be placed first not last, is to authorize funds for modernizing these facilities. At the present time, the PHS hospitals are so deteriorated due to the Department of HEW's policy of neglect, that in many cases dangerous situations exist.

The hospitals have been systematically starved by the Department of Health, Education and Welfare for years of all funds for modernization. The buildings themselves are old and need more and more frequent repairs.

The deterioration of the hospitals has had an adverse effect on staff retention, which was already a problem in itself due to the apparent short future of the PHS system. Faced by unair-conditioned buildings, overaged equipment and other problems, staff members of PHS hospitals have increasingly turned to private practice.

If these hospitals are to continue to be functional, viable health care delivery systems, and if they are to serve the increased patient populations envisioned by HR 16755, then they must be modernized to the extent they would have been had the Department of HEW carried out its responsibilities. Otherwise, they will die

of neglect and staff attrition and the Department of Health, Education and Welfare will have gained its objective without a struggle.

The cost for a renovation program is variously estimated to be from $125–$175 million. The figure rises quickly, as hospital construction costs also rise. Thus, the longer the delay, the more such a program will cost.

The AFL–CIO Maritime Trades Department urges that an authorization be placed in HR 16755, which will appropriate funds to cover the required costs of modernizing the eight hospitals and twenty-six clinics of the Public Health Service, spread over a five-year period.

Such a program, coupled with the new PHS mission contained in HR 16755, would provide the impetus for a revived and modern PHS system.

This hospital system could be the testing house and leader of all the nation's hospitals. It could show the way to low cost, quality and readily available medical care for every American.

The United States today faces a health care crisis. Only if we fully utilize and develop health resources such as the Public Health Service can this nation begin to conquer its many health problems.

HR 16755 when amended to include the safeguards suggested by the AFL–CIO Maritime Trades Department, will be the vital first step towards this goal of maximization of America's health resources.

Mr. Rogers. I understand you and thank you, Mr. Moody. Your suggestions will certainly be taken into consideration. We appreciate the points you have made and your statement will be gone over by the committee and we will try to bring out those points that you are pointing up here and consider them very carefully.

Thank you very much. We appreciate your presence here.

Any questions?

Mr. Carter. No, sir. I just want to say that I do desire to keep those hospitals open.

Mr. Rogers. I am going to call next, Mr. Kincaid, who came in from Mississippi. Mr. Kincaid, the committee welcomes you. Your full statement will be made a part of the record and if you could highlight for us the points you think the committee ought to know, because of the time element it would be helpful.

STATEMENT OF MOSE E. KINCAID, REPRESENTING THE QUITMAN COUNTY COMMUNITY SERVICES, INC., MARKS, MISS.

Mr. Kincaid. Thank you, Mr. Chairman. My reason for coming here today is on behalf of the Quitman County Community Services project in Marks, Quitman County, Miss., at the request of Congressman Metcalfe, and also at the request of the local people who are very much displeased with the drawback that they have had with the National Health Service Corps.

Quitman County is located in the delta part of Mississippi, about 65 miles south of Memphis. It has about 16,000 people with about 9,000 blacks. There are about four doctors and the ratio is 1 to 4,000.

Quitman County has been ranked as one of the poorest counties in the Nation and it is also one of the densest populated counties in the Nation. It is low in education, it is low on the poverty scale, it is low in family resources, educational achievement and, most important for the moment, it is low in health status and health care.

This project, which is an offshoot of the Howard University Mississippi project, commonly referred to as HUMP, was organized in 1969. It is a locally controlled group. It has a 13-member board, all from Quitman County. The project has as its primary goals: To establish a family health center, and next it tries to encourage community health

and education participation, it tries to foster programs in housing, and most of all it tries to create a vehicle for the assessment of community needs.

Overall, this project tries to alleviate misery and suffering and tries to develop a reasonable level of care among those who are not able to pay today and certainly would be unable to pay tomorrow. This clinic has made many attempts to get funds from HEW. It was denied a Division of Community Health Service grant in 1971. It was denied a Family Health Center grant in 1972. In October of 1971 the project submitted a proposal to the Freedom From Hunger Foundation here in Washington and was given a small grant of $14,124.78. With this little grant, the clinic opened on April 1 with a medical director, administrative director, and eight health aides. These health aides were trained by the National Medical Association and the American National Red Cross. The clinic rendered medical services 1 day a week until August 1, when the attending physician, who was 69 at that time, retired.

During the weekdays the clinic offered general administrative assistance, community health education, and ideas for housing projects and the like. As the clinic stands now, it is presently operating in the areas of general administrative relief, without rendering medical services.

With the efforts that we have made in trying to secure physician power and the efforts that we have made in trying to contact the National Health Service Corps both on the regional and national levels and being told on the national level that we should go back to Mississippi and contact State officials, who had just outright stomped us in the face and being told by Region 4 that due to their investigation or inquiry, it would be useless for us to file a formal application, and the fact that we have tried to negotiate with the local officials to get past the point of the National Health Service Corps Act which requires local certification, we were refused support on both of our proposals to HEW; we were refused support on our attempts to get the National Health Corps physician, and reverting back to Region 4. Region 4 supposedly contacted the State office at Jackson, Miss., and the district office—I think they call it Federal Clearinghouse, which revealed to them that there is no need for this particular group to file the application.

We don't want to end up in a position like our neighbors, namely, the Mound Bayou project which was denied the National Health Service Corps physician because the local AMA society did not approve of it, when, in fact, the NMA society approved it. We have the National Medical Association approval, too. The same is true of Marianna, Ark., project. The same is true with Tuskegee, Ala., which didn't get the approval, the application being deferred because the local medical society did not approve of it. So, what we are asking is for some type of help, some type of relief, to get past the point where we, being a local nonprofit organization, mostly controlled by blacks in Quitman County, can look to our Congressmen and the legislature to enact legislation that will help alleviate some of the turmoils that we live under to get past the point of having to go to the local medical society for actual certification of the National Health Service Corps application.

So all we are asking is that H.R. 16545, which we strongly endorse, be considered and passed, and that these arbitrary, capricious powers be stricken out because it has come to our attention in Mississippi and you gentlemen are aware of the shortcomings in Mississippi, that of the 82 counties, approximately six or seven counties have applied to the National Health Service Corps, and these were predominantly black organizations, and truly all of the organizations were organized to serve the less fortunates, and all of these organizations were denied because of this clause about the local medical society and dental society having to approve.

(Mr. Kincaid's prepared statement follows:)

STATEMENT OF MOSE EDWARD KINCAID, REPRESENTING THE QUITMAN COUNTY COMMUNITY SERVICES, INC., MARKS, MISS.

Mr. Chairman and distinguished members of this Committee, I welcome this opportunity to come before you and share some of our experiences in attempting to provide health services to an unserved population in Quitman County, Mississippi. Before I do, I should like to tell you a little about my background. I am a life long resident of Quitman County; a '69 graduate of the University of Mississippi School of Law; a practicing attorney in the County and the Project Director of the Quitman County Community Services, Inc., which I am representing today.

This is not a federally supported project. There are no funds inuring from local or state agencies. We have no special interests except the Health of the Quitman County residents and we do not represent any special interest groups. Our primary objective is to attempt to provide health services to the less fortunate residents of Quitman County, Mississippi. Gentlemen, let me say even though I am an attorney by profession, there are many persons in Quitman County who are not involved in the medical arena, but who have a sincere yearning to remove the blood stained banner which has plagued this forsaken community from the date of its founding. This is not to say that there are no health personnel in the area.

Quitman County is located in the delta of Mississippi, approximately 65 miles south of Memphis and 40 miles west of Oxford. The basic economy is agriculture and due to mechanization and technology, there has been a black exodus to the urban areas. According to the 1970 Census Report, the population of Quitman County was approximately 16,000 people, of this number, about 9,000 were nonwhite. The average gross family income was approximately $1,000. The County contains 495 square miles and is 18 miles at its widest point and 6 miles at its narrowest point. It is one of the most densely populated counties in the State of Mississippi and contains about 50 people per square mile. It has been designated as one of the poorest counties in the nation, up to but not excluding Washington, Tunica and Sharkey Counties.

According to a 1967 Office of Economic Opportunity Community Profile Project Report, Quitman County ranked or was designated as "*extreme*" in its magnitude of poverty; severity of poverty, family resources, functional illiteracy, sufficiency of housing, educational achievement and most important for the moment; "extreme" in both health status and adequacy of health care. According to most other indicides of health care, the county ranked in the lower 99th percentile of all counties in the nation. There are currently 4 doctors in the County. The Doctor-population ratio is 1:4000. There is no hospital, public or private, in the County. The closest hospital is located in the next county—Coahoma, and it is 18 miles away. Because the Coahoma County Hospital has a near 100% occupancy rate, it is of little functional use to the residents of Quitman County.

The Quitman County Community Services Corporation was founded in 1969 and duly chartered by the State of Mississippi. It is a locally controlled corporation with a 13 member board, all residing within Quitman County. The Howard University Mississippi Project, commonly referred to as HUMP, was instrumental in encouraging the local residents to form the corporation. A group of students from Howard's College of Medicine and Dentistry did a survey of the overall health needs of the residents of Quitman County in 1969. This study confirmed

that there was a critical shortage of medical facilities and manpower. Their data was identical and superimposable to that data already published by the Allied Health Director of the State of Mississippi and the Office of Economic Opportunity.

The primary objectives of the Quitman County Community Services Corporation are: to establish a family health center; develop and encourage community health education and participation; foster self help programs and create a vehicle for the assessment of the communities needs. The overall goal of the project is to alleviate misery and suffering, and to develop a reasonable level of care among those unable now, and certainly unable tomorrow, to pay for their care.

The Project presently has a physical plant valued at more than $75,000; this being the gift in 1970 of the United Auto Workers—Solidarity Technical and Educational Programs (UAW–STEP). The unit has two examination rooms, 1 laboratory, reception area, laboratory and X-ray room. Equipment includes an X-ray machine, EKG machine, microscope, and examination table.

Our ability to provide medical services and meet our objectives has been sufficiently hampered by the refusal on the part of HEW to grant two requests. An application was submitted to the Division of Community Health Services in HEW. We were at that time requesting funds for a 314e project. Our 314e application was denied. The excuse being there was not enough money to fund Fayette and Marks. In July, 1972, again, application was submitted for a Family Health Center grant and was denied July, 1972. Even though the need was confirmed by HEW in both cases, the applications were denied.

In October, 1971, proposal was submitted to the American Freedom from Hunger Foundation at Washington. This urgent request was approved and a grant made in January, 1972 for $14,124.78. With this small grant, the Quitman County Community Services began rendering services on April 1, 1972.

The clinic was staffed with an administrative director, medical director and eight health aides. The aides were trained by a Joint National Medical Association/American National Red Cross effort. The clinic operated each Saturday until August 1, 1972. At that time the attending physician, age 69, retired. Even though services were rendered only 1 day each week, the project offered many innovations in health education, general administrative assistant, and other supportive services during the week. People were attracted to the services not only from Quitman County but from the surrounding counties. The closing of direct services now meant that we were once again faced with an infant mortality death rate twice that of this state coverage and 4 fold of the nation.

It means that once again without adequate emergency services for those that cannot pay—simple emergencies become life threatening.

It means that our programs in health education—which were also on extension of the providers service—were no longer coherent.

It means that a system of cost diagnosis—developed by the community board members—could not be implemented.

It means that a four year struggle by poor citizens to address and answer their health needs—would surely be turned away again because of the need for a provider.

We have only one hope, the National Health Service Corps, which we understand is to be the outgrowth of the "Emergency Health Personnel Act of 1970."

Gentlemen, our project has contacted the National Health Service Corps on both the national and regional levels. We were told from the national level to contact state officials. Region IV informed us that it would be useless to file a formal application because inquiries revealed that we would not get certification. We do not want to be plagued with the problems of some of the poorer counties in the area.

For example, the Lee County Cooperative Clinic's (Marianna, Ark.) application was one of the first round applications to be considered by the Corps. The Clinic had the certification of the National Medical Association (which is required by P.L. 91–623, The Emergency Health Personnel Act of 1970) and was disapproved by the Corps because of the American Medical Association (AMA) would not certify the application.

A more recent situation is Mound Bayou, Mississippi. The community of Mound Bayou was sent a letter from the Director of the National Health Service stating that their application had been deferred because of the lack of certification of the American Medical Association and the American Dental Association, although the National Medical Association had certified the application.

The Mound Bayou situation is a clear cut case where the primary providers (NMA) of health care are not considered as the appropriate health society. Another similar case where a community's request was delayed is Tuskegee, Alabama.

P.L. 91–623 states that a community request must have the certification of the state and district medical societies. It does not state that this cerification should be the American or National Medical Association. According to the Senate Report (92–1062), as of July 26, the state and local medical and dental societies have refused or delayed certification of the needs of some 17 physicians and 11 dentists.

We wholeheartedly support H.R. 16545, a bill that would simply remove this arbitrary power of the state and local medical societies.

Mr. Rogers. Well, I think that points up for this committee a situation that we certainly will look into. Your testimony, I think, gives us the specifics and it is shocking to me that this would exist and the committee will look into this situation.

Mr. Carter. It is almost beyond imagination. I would like to add that I regret that it is all too true.

Mr. Rogers. We appreciate your presence here. The committee will ask for an explanation to see what can be done, and we will consider this when we write the legislation. Thank you so much for your presentation here today. We are grateful for your coming up here, Mr. Kincaid. It has been most helpful to the committee.

Our next witness is Dr. John A. D. Cooper, president, Association of American Medical Colleges.

We welcome you.

STATEMENT OF DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Dr. Cooper. Thank you. Because of time, I will summarize very briefly here the positions that we have made in our written testimony.

The association is fully in support of the National Health Service Corps. We supported the initial bill when it was enacted and we believe that it should be extended in this session of Congress. We think it will be of help in solving some of the problems related to the distribution of physicians and other health professionals.

We are also concerned about the ability to attract an adequate number of physicians and other health professionals into this corps with the disappearance of the draft. We think that the loan and scholarship programs will be helpful. We would like to point out, however, that except for the State of Kentucky, which has an excellent record for its program to bring the physicians into the rural health areas through a scholarship program, this has not been equally effective in other States. In some 11 States that have this program, only about half of those who are in the scholarship program or loan program ultimately end up in the rural health areas. They buy out.

I am sure that Dr. Carter knows that 98 percent of students in the rural physician scholarship program in Kentucky do fulfill their obligations and practice in the rural areas of Kentucky. We hope that the loan and scholarship program to attract physicians and other health professionals into the National Health Service Corps contained in this legislation should be at least equivalent to that available through the Department of Defense, and scholarships should

provide not only stipends but also tuition and other necessary expenses for education.

We think that the loan forgiveness provisions of the bill are excellent and would be attractive.

Mr. CARTER. Doctor, wouldn't you like to go to school now?

Dr. COOPER. Yes, sir. We think that the provisions of your bill may be unnecessarily restrictive in that it provides this kind of support only to those who will go into Public Health Service's Regular Commissioned Corps. We think this may bar some very highly motivated students who wish to join the National Health Service Corps and practice medicine in certain areas, but who either do not wish to accept or may not be qualified to meet the rigid requirements for appointment to the Regular Commissioned Corps. So we would suggest that the committee consider providing the same kind of support for those students who would enter the National Health Service Corps through the civil service option.

In addition, I would like to recommend that another way to make the program more attractive to students is to establish some relationship to medical centers. We think that a program which relates the National Health Service Corps to the medical centers can provide both professional managerial support for the membership of the Corps. We believe it is very difficult for these people to be parachuted into an area without some sort of tie to an existing institution. Another impotrant aspect of this relationship is the real possibilty, through arrangement with the academic medical center, for members of the Corps who have not completed their requirements for specialty certification to receive credit toward their Board requirements. We have in our testimony a recommendation for this committee to consider which would permit this kind of relationship to be established.

Mr. ROGERS. Is this on page 5?

Dr. COOPER. Yes, sir. We have been working with the Health Services and Mental Health Administration and the administration of the National Health Service Corps on such a program. It has not yet been acted upon favorably.

Mr. ROGERS. Did you say it had or had not?

Dr. COOPER. It has not. It has been held up and has not been acted upon.

Mr. ROGERS. I thought they told us they were in complete agreement.

Dr. COOPER. We are very anxious to get this Corps to work. and we want to do everything we can from the medical schools to make it work. Those, I think, are the main points.

Mr. ROGERS. Well, I think those are good suggestions. I don't know why the particulars can't work out some continuing programs for them to do some residency work while they are doing this. It seems that would be very helpful.

Dr. COOPER. Secondly, one could provide that when the individual is sick or wishes to have some leave time, a resident or faculty member could take care of his duties. Furthermore, he could have a mature individual back at the medical school with whom he could get on the phone and discuss particular problems. These are the reasons why we proposed that the Corps be related to the medical centers. The proposal has not yet been accepted by the Department.

Mr. Rogers. Well, I think that makes sense. It seems to me that makes sense and I am sure we would like to take that into consideration.

Mr. Carter?

Thank you. We appreciate your appearance. Your complete statement will be printed in the record.

(Dr. Cooper's prepared statement follows:)

STATEMENT OF DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman and members of the subcommittee, the Association welcomes this opportunity to testify on the legislation to improve the program of medical assistance to areas with health personnel shortages.

Formed in 1876 to work for reforms in medical colleges, the Association has broadened its activities over the years, so that today it represents the whole complex of persons and institutions charged with the undergraduate and graduate education of physicians. It serves as a national spokesman for all of the 111 operational U.S. medical schools and their students, 400 of the major teaching hospitals, and 51 learned academic societies whose members are engaged in medical education and research.

Through its members, the concerns of the Association range far beyond medical education itself. They include the total health and well-being of all the American people. The Association is concerned with the education and training of persons in other, related health professions and in allied health occupations. It is concerned with the conduct of a substantial portion of the nation's medical and health care research. It is concerned with the delivery of health care, directly through the facilities of teaching hospitals, and indirectly through te development of improved community health services. It is concerned with innovation and experimentation in all of these fields. The Association and its membership thus have a deep and direct involvement in this legislation.

LEGISLATION

The principal legislative proposal before the subcommitee is a measure, the Emergency Health Personnel Act Amendments of 1972 (HR 16755), introduced by Chairman Rogers and other members of the subcommittee to improve the program of medical assistance to areas with health manpower shortages. The bill extends the National Health Service Corps, provides for new efforts to recruit volunteers, broadens the forgiveness features of health professions student loans for persons agreeing to serve in the Corps, and establishes a special new scholarship program for volunteers. In addition, the bill contains other provisions modifying the legislative authority for the Corps and limiting the Secretray's authority to close or transfer Public Health Service hospitals.

Senate-passed companion legislation, designated S 3858, also is pending in the House.

ASSOCIATION COMMENTS

The principal goal of the National Health Service Corps as stated in the Emergency Health Personnel Act (P.L. 91–623) is "to improve the delivery of health services to persons living in communities and areas of the United States where health personnel and services are inadequate to meet the health needs of the residents of such communities and areas." This is to be accomplished through the assignment of commissioned officers and Civil Service personnel of the Public Health Service to areas or communities of need. This program is intended to help in overcoming shortages of physicians and other health manpower, and will provide relief to specific communities that request National Health Service Corps personnel, indicate willingness to provide necessary community support for personnel, and meet criteria for such services.

The Association of American Medical Colleges has long been deeply concerned by the geographic maldistribution of physicians in the United States. Because of its concern, the Association strongly supported enactment of the 1970 National Health Service Corps legislation. In fact, the Assembly of the Association, its highest governing body, adopted a policy statement at the November 1970 annual meeting that called for enactment of the then-pending legislation. (A copy of the policy statement is attached to this statement.) The Association's support for the National Health Service Corps has remained strong and it warmly recommends

approval of those provisions of HR 16755 designed to extend the Corps for an additional three years, through June 30, 1976 and to expand and improve the recruitment of personnel for the Corps.

The proposed modification of the loan forgiveness provisions of the Comprehensive Health Manpower Training Act of 1971—to provide accelerated forgiveness to members of the National Health Service Corps—is a hopeful effort to encourage increased participation in the Corps. The Association must point out, however, that other student aid programs tied to service commitments of some kind have demonstrated only questionable effectiveness. A study of such programs, reported in the July 1971 *Journal of Medical Education*, found that some programs operated by states have been eliminated because they were not achieving their goals at all, while the majority of states were fortunate if 60 percent of the borrowing physicians followed through by practicing in rural areas of the states.

The proposal in HR 16755 to establish a new scholarship program for students who agree to accept commissions in the Regular Corps of the Public Health Service deserves special comment. In the Association's view, such scholarships, restricted only to those individuals who agree to become commissioned officers in the Public Health Service Regular Corps, are an undesirably and excessively narrow basis for attracting recruits to the National Health Service Corps. Such a limitation would bar benefits to highly motivated students who wished to join the National Health Service Corps and to practice in medically underserved areas but who either did not wish to accept, or may not be qualified to meet, the rigid requirements for appointment in the Regular Commissioned Corps of the Public Health Service. The Association supports establishment of a scholarship program aimed specifically at students in the broad range of health professions and occupations who wish to serve in the National Health Service Corps. To achieve this end, the Association suggests that participation in such a new scholarship program be broadened to include any student who wishes to serve in the National Health Service Corps, regardless of whether he wishes to serve as a commissioned officer or as a civil service employee of the Public Health Service. Such an approach has been included by the Senate in S 3858.

As an additional matter, the Association would like to emphasize the essential need for the availability of strong backup resources to support the activities of National Health Service Corps volunteers. Experience with other U.S. volunteer groups, VISTA, and the Peace Corps, has demonstrated the necessity for volunteers to receive professional, educational and other support services. The need for a professional link to whom the isolated volunteer in the field can turn for advice and consultation has been proven to be of great programmatic support for maintaining the volunteer in the field. Such linkage would contribute to the maintenance of efficiency and morale of the National Health Service Corps volunteers and could be a significant factor in the future of the program. The academic health centers of the nation span all the groups likely to be represented in the National Health Service Corps program and could form the base for the development of an institutional focus to support the multiple disciplines involved in any one assignment under the program.

Specifically, there needs to be established a program to provide preceptors for National Health Service Corps professionals. Because patient referral for consultation in all of the disciplines will likely take place at an academic health center, the center presents an obvious and ideal site for preceptorial activity. As a member of an academic health center, the preceptor would be able to bring to bear the resources of the institution on the needs of the volunteer. This would include making accessible the consultative resources of the institution; the managerial aspects of the institution; and the data processing, evaluation and research capabilities, and the outreach and support mechanisms of the academic health center. Furthermore, evaluation of individual National Health Service Corps members is feasible only if there is a strong preceptorial progam in effect. This would require joint participation of faculty and representatives of medical specialty boards. In addition to assisting the Public Health Service in its own determinations of the performance of National Health Service Corps personnel, preceptors and peer evaluation could also help in determining which groupings of professional and supporting staff are effective in service delivery and in maintaining staff support.

The Association strongly recommends to the subcommittee consideration of the resources-base and precepetorial concepts as useful improvements in the National Health Service Corps program. These concepts could be implemented through the addition of new language to the special projects authorities in the Comprehensive Health Manpower Training Act of 1971. The Association sug-

gests amending section 772(a) of the Public Health Service Act by adding the following after subsection 772(a)(13):

"(14) provide advice, consultation, technical assistance and special evaluation, training and preceptorial services in support of the conduct of the programs of the National Health Service Corps and of the activities of its members."

In the subcommittee's review of the National Health Service Corps program, the Association hopes it will consider the impact on medically underserved areas of the extremely narrow range of health care services provided through the National Health Service Corps. The addition of health care personnel to areas which previously lacked such personnel is unquestionably beneficial. It is certain to raise hopes and expectations about future health care services in the minds of the residents of these underserved areas. However, without a concomitant increase in the full range of health care resources with which those heightened expectations can be brought to fruition, the mandate of the National Health Service Corps—to improve the delivery of health service to underserved areas—can never be successfully carried out. The Association is terribly disturbed by the inadequacy of the National Health Service Service Corps program when measured against the true health care needs of underserved areas. In an effort to secure at least an examination of this broader issue, the Association urges the subcommittee to require, as a part of a National Health Service Corps assignment to an area, a report on the health care resources present in the area, the additional resources needed to sustain an adequate level of health care in the area, the availability of existing federal assistance to provide such additional resources, and recommendations for any additional legislation necessary to improve the delivery of health services to the area.

RESOLUTION IN SUPPORT OF THE NATIONAL HEALTH SERVICE CORPS ACT

Whereas, there is growing interest among medical students, physicians in training and other health professionals in public service, particularly to the poor and disadvantaged;

Whereas, there are serious problems in the provision of health services to the poor and those living in rural areas and in urban poverty areas;

Whereas, young physicians are required to serve two years of obligated military service or in the Public Health Service;

Whereas, the proposed National Health Service Corps will help to meet the problems of maldistribution of health professionals in two ways: first, by providing an infusion of health personnel into Federal health care programs in physician-deficient areas, and, second, by providing a program whereby health professionals can serve in poverty areas and determine if continuous service in such areas would be feasible as a careeer; be it

Resolved, That the Association of American Medical Colleges strongly supports the National Health Service Corps Act (H.R. 19246) and urges its speedy enactment.

Mr. ROGERS. Our last witness today—and we apologize for keeping everybody so late—is Dr. Richard E. Palmer, who is appearing on behalf of the American Medical Association.

Dr. Palmer, we appreciate your appearance. I am sorry we ran over so late this afternoon. If you would like, we will make your statement a part of the record and you could highlight it.

STATEMENT OF DR. RICHARD E. PALMER, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY BERNARD P. HARRISON, DIRECTOR, DIVISION OF MEDICAL PRACTICE, AMA; AND ROY S. BREDDER, ASSISTANT DIRECTOR, LEGISLATIVE DEPARTMENT, AMA

Dr. PALMER. Are you saying, Mr. Chairman, that I cannot give my statement.

Mr. ROGERS. No; you can do however you prefer. If you would like to highlight it, that would be acceptable, or if you prefer reading in its entirety——

Dr. PALMER. I would prefer reading it, Mr. Chairman.

I am Dr. Richard E. Palmer, a physician in the practice of pathology in Alexandria, Va., and a member of the American Medical Association's Board of Trustees. Accompanying me are Mr. Bernard P. Harrison, director of our Division of Medical Practice, and Mr. Roy S. Bredder, assistant director of our legislative department. We are pleased to present the views of the American Medical Association on legislation pending before you to extend and otherwise amend the Emergency Health Personnel Act.

On December 31, 1970, Public Law 91–623, the "Emergency Health Personnel Act of 1970," became law, authorizing a new Federal program whereby the Secretary of Health, Education, and Welfare could assign health personnel of the Public Health Service to areas with critical health manpower shortages, upon the request of a State or local health agency or other public or nonprofit private health organization. Such assignment of personnel required certification by the State and district medical, dental, or other appropriate health societies, and by the local government, that such health personnel are needed.

The National Health Service Corps program has been operational a little over half a year. The first 18 communities to which Corps members would be assigned were announced on January 28, 1972, and it was several months later that personnel actively began to fill their assignments. It is our understanding that 144 communities have now been assigned health personnel. This is an auspicious beginning for a program which promises to help alleviate the maldistribution of health personnel affecting shortage areas.

Mr. Chairman, funding under Public Law 91–623 expires on June 30, 1973. We support a 3-year extension of authorizations of this program as proposed in your bill, Mr. Chairman, H.R. 16755, as well as that in S. 3858, passed by the Senate. All of the bills pending before the subcommittee would make several changes in the existing program, and we will address our remarks to certain modifications.

A significant change in Public Law 91–623 would be effected under H.R. 16545, by deleting the requirements for certification by State and district health societies that such health personnel are needed. Instead, the Secretary would be authorized to assign Corps personnel to a shortage area. Under S. 3856, the requirement for certification would be retained, but where the Secretary finds that such certification had clearly been arbitrarily and capriciously withheld, then the Secretary may, after consultation with the appropriate health societies, assign personnel into the area. On the other hand, your bill, Mr. Chairman, would retain certification requirements contained in existing law.

We believe it is correct to say that no one has anticipated that the National Health Service Corps would, on its own, permanently solve the problems of health manpower shortages. These problems are complex and include a host of factors. But Public Law 91–623 chose an imaginative and unique approach, one aimed at integrating the young physician into the community. It may be fairly said that without this emphasis on integration—especially the professional aspects—most, if not all, of the assignees would serve their 2 years and then leave for more favorable settings. And then, if the national interest in the National Health Services Corps wanes in the years to come, the

area can be expected to revert to its former status of urgently needing health manpower, having experienced only a temporary respite.

When the program was first considered, it was generally recognized that the potential of NHSC was in providing, on a short-term basis, the health manpower needs of a community until these could be met on a continuing long-term basis. Later, there developed the laudable idea that the program could include the concept that the professional person who is assigned to the community would remain in the community after completing his Federal tour of duty. Accordingly, much of the Corps planning to date has been centered around community participation in the NHSC program to further encourage the physicians, dentists, and other professionals to feel they are part of the community life. We urge this committee not to take any action now which would block communities and professionals from attaining this goal.

Certification by the physician's or dentist's peers—the local members of his own profession—that his services are needed, together with concurrence by local government, provides the strong and necessary base of community acceptance and participation in his assignment. Removing this base could erect barriers and prevent the level of contact and rapport with peers which are significant factors in stimulating the professional man to establish professional roots in his community.

Furthermore, the record of cooperation by the medical profession at the local, State, and national levels speaks against the proposed amendment deleting the certification provision. The American Medical Association has worked closely with the National Health Service Corps to help make the National Health Service Corps a reality. Publications of our association have repeatedly contained news stories reporting Corps activities. Dr. H. McDonald Rimple, Director of the Corps, was a featured speaker at the association's 25th National Conference on Rural Health in March of this year, and again at the AMA's Health Manpower Symposium in San Francisco this past June. Other Corps representatives have been involved in other association meetings.

At the Corps' request, the American Medical Association has also distributed to all State medical associations and county medical societies brochures on the program, together with lists of NHSC personnel in central and regional offices to be contacted, requesting assistance in identifying areas particularly short of health manpower. All of these activities, and others, have been undertaken to inform State and local medical societies of the program's interest, method of operation, and goals.

Most recently the association has contracted with the Corps for the AMA to recruit physicians to serve in areas of need on a short-term basis. This undertaking, which we call Project U.S.A., will be a valuable adjunct to the Corps in its operational phases of its program.

In short, Mr. Chairman, the American Medical Association has actively provided assistance in the implementation of the National Health Service Corps. The medical profession shares with you, with your committee, with government, and with communities the common goal of getting needed medical services into shortage areas.

Even more directly than our activities at the national level, we believe that the measure of success to date of this new program can be attributed to the cooperation received at the local level from the

various medical communities. It should be kept in mind that the great number of assignments of physician personnel made in this program to date have been possible because the local and State societies have certified to the need for such health personnel. As a fact, in some instances, the medical society has been a moving party in seeking assignment of personnel under this program.

Mr. Chairman, we believe that the foregoing is strong evidence that the active participation of organized medicine is to the advantage, and not to the detriment of the program. We must assert strongly that we are opposed to the deletion of the present certification requirements in the law. The record of cooperation warrants continuing these requirements. The absence of such requirements could defeat the goal we all share.

Accordingly, we strongly urge that the present requirement of the law requiring State and district health societies (as well as local government) to certify the need for personnel in such area, be retained, as would be done under your bill, Mr. Chairman, H.R. 16755. The amendment in H.R. 16545, under which certification would be eliminated, should be rejected, as should the provision in S. 3558, authorizing the Secretary to overrule the society's determination. We believe the Senate provision to be unnecessary.

Before discussing other provisions in the legislation, we would like to comment on one additional point. Once again, the thrust of the National Health Service Corps program is to meet the problems of health manpower shortage areas. It is not a program primarily designed to assist the financially disadvantaged. For example, we understand that approximately 80 percent of the approved communities have been rural, and only 20 percent have been what might be called innercity areas. In this context, then, it serves the congressional intent to have the health and medical services provided in a manner and under arrangements similar to those already existing in the community. Charges for professional services are either retained by the community or apportioned between the Federal Government and the community. These charges should be at the same level for the patient who is financially able to pay, as are those charges generally prevailing in the community. When the time comes, following this principle will allow for an easy transition from Government sponsorship to total community involvement.

Other provisions of the bills before you are also of interest and concern to the profession. I will touch on some of them briefly.

Section 329(d) of the Public Health Service Act would be amended apparently to require the use of PHS facilities and hospitals in the area to be served, in providing care and services in the program. Under the original enactment the Secretary has latitude in making such arrangements as he determines necessary, utilizing all health facilities of the area to be served. We recommend a continuation of the present provision, as providing greater flexibility in the interest of better patient care in the community.

The bills also amend provision of Public Law 92–157, the recently enacted Comprehensive Health Manpower Training Act of 1971. Under that act students of medical and other health professional schools who receive Federal loans may have these loans canceled in part where they engage in their professions in manpower shortage

areas. These newly enacted provisions, signed into law only last November, greatly liberalized the previous cancellation provisions by increasing the rate of cancellation to 30 percent for the first year, 30 percent for the second year, and 25 percent for a third year of such service. While these new provisions would continue to remain applicable to other students serving shortage areas, the bills provide for special treatment of students serving shortage areas through the National Health Service Corps. For each year of NHSC service the loan would be canceled at a rate of 50 percent, thus canceling in full the loan obligation at the conclusion of a 2-year enlistment period. Mr. Chairman, the result would be that the student who voluntarily chooses a shortage area and is more likely to stay receives 85 percent forgiveness for 3 years' service, while the Corps physician would receive 100-percent forgiveness for 2 years' service. The end result could be a shorter term of service to the community. Service in the Corps should not be accorded preferential status when it should be our objective to encourage the establishment of medical practices in shortage areas on a more stable, continuing basis. A uniform rate of cancellation should apply to all persons serving in shortage areas.

The bills would also create a special scholarship program. Under the program, students agreeing to serve in the Corps at the conclusion of their training could receive a scholarship. While we support scholarships for medical training, we question the advisability of creating such a separate program, with its long range implications, where the NHSC itself must be regarded as a pilot or experimental program at this time. If it is found that additional scholarships are needed for medical students, additional funds could be provided through the newly expanded provisions of the scholarship program under the recently enacted Health Manpower Act.

In closing, Mr. Chairman, we support an extension of the fledgling NHSC program. Because of its newness, its capabilities for bringing needed services into shortage areas are yet to be fully demonstrated. Additional experience will permit a fuller evaluation of the program's potential. In supporting the National Health Service Corps, however, we believe it is essential that incentives now contained in the program are retained so that we may hopefully achieve our overall objective of meeting community needs on a long-term, continuing basis.

We express our appreciation for the invitation extended by the committee to us to give our views of this legislation. We shall now respond to any questions which the committee may have.

Mr. Rogers. Thank you very much for your statement setting forth the AMA's position. It is most helpful.

Mr. Harrison and Mr. Bredder, we appreciate your being here.

Dr. Roy?

Mr. Roy. I thank you for your statement. I have a couple of questions. Do you think this program should be expanded?

Dr. Palmer. I would like to see it get off the ground. We feel that it has made a very fine start. As I pointed out, I think that 144 community areas have been served. We certainly stand firmly behind the concept that is involved and hope that by virtue of the National Health Service Corps we can encourage young men to join the Corps and to go to those communities and hopefully integrate into the community and be a part of the community.

Mr. Roy. I am constantly asked the question of how are we going to get doctors into our underserved areas, especially the less populated rural areas. What is your answer to that question?

Dr. Palmer. I don't have an answer to that. I will tell you, frankly, that I have spent a lot of time thinking about it. The American Medical Association, as you know, had a very active committee for 2 years on health care for the poor. We went into rural health care and innercity health care. We had many suggestions, none of them have, to the best of my knowledge, been entirely productive in getting the physicians into these needed areas.

I think you should know that the American Medical Association has sponsored two mobile units in innercity Chicago in conjunction with the Chicago Medical Society. This program has been so far eminently successful. We look forward to great things from this type of activity. Perhaps in the future, something of this sort may partially answer the question.

Mr. Roy. Would you support heavy bonuses and large scholarships? In other words, bonuses heavy enough or scholarships large enough to make sure that we get enough people both in our armed services and in the Public Health Service?

Dr. Palmer. Well, I certainly think the American Medical Association believes incentives should be great enough to attract people into service areas that ordinarily would not attract them, yes.

Mr. Roy. One other question. We were told by Dr. Rimple that 24 medical societies, local or State, found that there was not a need for the physicians that they proposed to assign in there. He said since that time, seven have been able to come to terms, so that if my mathematics are correct, 1 time out of 6 there has been a veto on behalf of the local profession. And 1 time out of 8 there is still apparently that existing veto. Do you have any knowledge of these particular situations?

Dr. Palmer. I heard his testimony before this committee. I thought he said there were 17 areas——

Mr. Roy. He said there were 24 where there were vetos, and they have been able to work out seven, so they had a balance of 17, with the dentists there were 31 and they were able to work out seven, so they have a balance of 24. Anyway, this comes to 1 out of every 6 where they had an original failure to certify and 1 in 8 where there has continued to be a failure to certify need. Do you have any idea why the local or State societies felt that there was no need for physicians in these areas?

Dr. Palmer. I, personally, have not been privy to that information. Mr. Harrison, I think, does have some information, Mr. Chairman, if he may speak to this point.

Mr. Harrison. Only in a general way, Mr. Roy. I have looked at the information that I received from the National Health Service Corps. We have worked very closely with them in trying to implement this program and in providing some of the educational materials. This was in a campaign, you might say, to have the young physicians join the corps. Dr. Palmer has related our own project USA, which the AMA is participating in by providing physicians on an interim basis to help the young physicians to get started or to give them an opportunity to participate in some of those activities that were related earlier

in the testimony; that is, going to medical school or getting some additional training or attending symposiums.

Now, I have looked at some of these where the rejection was made and I think we found, in at least a few cases, that the Corps itself has agreed with the denial. You must remember that the application comes in and it is indicated that no certification can be had from the medical society and then the corps follows this up as to reasons. In some of the cases, the medical society, for instance, one in Pennsylvania said that this particular area was not one of the shortage areas in the State. It has certified other areas and offered to find other areas that were more critical, at least at the present time, with the shortage of manpower available for the program. At least in some of the 17 cases you might say that the denial, at least at this time, was realistic in consideration of where the program stands. In other cases, through educational processes through both the AMA and the State medical society working with the National Health Service Corps, we have been able to turn around about seven of the 24, and I think that that can happen in a few more.

We believe it is extremely important to recognize in the main there has been good support from the medical societies and the local physicians and this will enable the program to flourish rather than possibly be undermined at an early date.

Mr. Roy. Do you think that any of these decisions have been capricious and arbitrary?

Mr. Harrison. I can't answer that but I think that some of the decisions didn't have a realistic basis for their denial, at least on the information that we have at the present time and they have been investigated further. I would not be able to say that under no circumstances would the area be denied certification in an arbitrary manner, but the important facet here is to recognize that the program is just getting underway and we have kind of total support from the medical societies and the professional people involved and we are encouraging that kind of support on the basis that they become involved at the very early start of the program. We would like to keep that that way because we think that is important in gettting this program underway.

Mr. Roy. Can you submit to us a discussion on the 24 areas this occurred in and some of the circumstances? I am not going to ask you about this decision but——

Mr. Harrison. Actually, I can provide you the information that the National Health Service Corps have provided itself and I would be glad to list the 24 areas.

Mr. Roy. And what their comments might be?

Mr. Harrison. I understand that. It may take a little while. It may not be ready for your record but I would get that.

(The following letter was received for the record:)

American Medical Association,
Division of Medical Practice,
Chicago, Ill., October 18, 1972.

Hon. Paul G. Rogers,
Chairman, Subcommittee on Public Health and Environment, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C.

Dear Congressman Rogers: On September 28, 1972, when testifying before your Subcommittee on H.R. 16545, H.R. 16755 and S. 3858, I offered to provide for the record a list of the communities whose proposals for participation in the

National Health Service Corps program had not been certified by local or state medical societies as areas of critical shortage.

As you may recall, I indicated that 144 communities were being provided health and medical services by the National Health Service Corps program which has been operational a little more than six months. Only 17 requests for medical services were disapproved, and it is our understanding that two of these were subsequently resubmitted and received favorable consideration, and that another request was withdrawn on the basis that adequate health service was available from a nearby source. The small percentage of denials for certification (less than 10%) seems to us as reasonable for a totally new and conceptually different program.

While we do not have, at this time, knowledge of all the factors which led to the denials of certification in all fourteen situations, our information does indicate that a lack of understanding and communications may have been the barrier in several cases. We assume that these will be returned for reconsideration.

As the program progresses and the criteria and mechanism for certification become better known, it is likely that there will be even fewer disapprovals for certification.

We have supported the mission of the National Health Service Corps and believe that we have played an important role in the development of the program. As you know, our "Project USA," funded by contract with the National Health Service Corps, provides for the American Medical Association to seek experienced physicians who can, for periods of short duration, assist the program.

In conclusion, we once again urge that you retain the opportunity for maximum participation by medical societies. The requirement for medical society certification means that, from the outset, the local NHSC physician will have the cooperation of his professional peers, and will allow for a relationship which encourages the young physician to remain in the area or community after his tour of duty has been completed.

Sincerely,

BERNARD P. HARRISON, *Director.*

COMMUNITIES WHICH HAVE NOT BEEN CERTIFIED FOR HEALTH SERVICES THROUGH THE NHSC

Bradford County, PA.; Mound Bayou, MS.; Washington, Co., N.C.; Walnut, MS.; Loudin Co., TN.; Polk Co., FL.; Holmes County, MS.; Wood County, OH.; Crystal City, TX.; Carrizo Springs, TX.; Eagle Pass, TX.; Corning & Villisca, IA.; Dewitt, NB.; and Antelope Valley, CA.

LISTING OF AREAS CERTIFIED AND APPROVED FOR NATIONAL HEALTH SERVICE CORPS ASSISTANCE

Bangor, ME.; Jackman, ME.; Berlin, N.H.; Lincoln, N.H.; Littleton, N.H.; Hardwick, VT.; Island Pond, VT.; Windsor, VT.; Cato, N.Y.; Chateaugay, N.Y.; Herkimer, N.Y.; Montour Falls, N.Y.; New York City (Bronx); New York City (South Bronx No. 34); Norwich, N.Y.; Perkinsville, N.Y.; Richmondville, N.Y.; Rochester, N.Y.; Sodus, N.Y.; Staten Island, N.Y.; Utica, N.Y.; Walworth, N.Y.; Wellsville, N.Y.; Washington, D.C.; and Baltimore, MD.

McDonnell Heights, MD.; Broad Top City, PA.; East Brady, PA.; Foxburg, PA.; Orbisonia, PA.; Philadelphia, PA (Pennsylvania Hospital); Philadelphia, PA.; Pittsburgh, PA.; Snow Shoe, PA.; Spring Mills, PA.; Susquehanna, PA.; Newport News, VA.; Wise, VA.; Wise, VA (Haysi); Elkins, WV.; Glenville, WV.; Huntington, WV.; Union, WV.; Cherokee, AL.; Florala, AL.; Haynesville, AL.; Heflin, AL.; Oneonta, AL. (100 Lincoln Avenue); Red Bay, AL.; Rockford, AL.; Tuskegee, AL.; Belle Glade, FL.; and Brooksville, FL.

Cross City, FL.; Decatur, GA.; Meigs, GA.; Pearson, GA.; Springfield, GA.; Louisville, KY.; Wendover, (Leslie County) KY.; Ashland, MS.; Greenwood, MS.; Jackson, MS.; Lexington, MS.; Philadelphia, MS.; Dublin, N.C.; Maxton, N.C.; Beaufort, S.C.; Charleston, S.C.; McCormick, S.C.; Moncks Corner, S.C.; Adamsville, TN.; Decaturville, TN.; Erin, TN.; Jamestown, TN.; Kingston, TN.; Monterey, TN.; Rutledge, TN.; Spring City, TN.; Springfield, TN.; and Surgoinsville, TN.

Tazewell, TN.; Watertown, TN.; Chicago, IL.; Kankakee, IL.; Rock Island, IL.; Seymour, IN.; Hale, MI.; Kalamazoo, MI.; Clinton, MN.; Columbus, OH.; LaCrosse, WI.; Green Bay, WI.; Lack Village, AR.; Lewisville, AR.; New Orleans, LA.; Gallup, N.M.; Santa Fe, N.M.; Tierra Amarilla, N.M.; Coalgate,

OK.; Hominey, OK.; Laverne, OK.; Marietta, OK.; Austin, TX.; LaMarque, TX.; Harlingen, TX.; Rio Grande City, TX.; Louisburg, KA.; and Kansas City, MO.

Mountain View, MO.; New Madrid, MO.; Ashland, NB.; Bassett, NB.; Curtis, NB.; North Bend, NB.; Rushville, NB.; Talmage, NB.; Center, CO.; Antonito, CO.; West Yellowstone, MT.; Langdon, N.D.; Bowbells, N.D.; Clear Lake, S.D.; Martin, S.D.; Sisseton, S.D; Tooele, UT; Brentwood, CA.; Chico, CA.; Isleton, CA.; Livingston, CA.; Rio Linda, CA.; San Bernardino (Mono County), CA.; Anchorage, AK.; Nampa, ID.; Fossil, OR.; Gold Beach, OR.; Ritzville, WA.; Seattle, WA.; Stevenson, WA.; Federal Way, WA.; Twisp, WA.; Immokalee, FL.; Lake Butler, FL.; and Waukegan, IL.

Mr. Roy. I want to reiterate what I said. Namely, I think it is important we have local cooperation. I hope that this situation of asking for a review and recommendation by the local societies and, in fact, certification can continue. Obviously, it is difficult for it to continue if there are glaring examples of abuse of this type of review, and decisionmaking by the local professional societies.

I thank you, Mr. Chairman.

Mr. Rogers. Dr. Carter?

Mr. Carter. Thank you, Mr. Chairman. Of course, I am a member of the AMA, as I am sure my friend, Dr. Roy is; is that correct?

Mr. Roy. That is correct.

Mr. Carter. And I share some of his feeling concerning this. It would be hard for me to explain how in Mississippi where we have one county with 16,000 people and only four physicians, which was denied a physician in there. It seems to me that that might well be very capricious and arbitrary. I would like to look into it very closely and certainly see where there is evident need that something be done, and I know Dr. Palmer well enough to know that he would try to correct the situation and I feel that the gentleman would do so also. But that sort of speaks for itself.

I can see where there has been a serious mistake made and I hope it will be corrected.

Dr. Palmer. Dr. Carter, we will look into this. I might add that the AMA has had a longstanding policy of antidiscriminatory actions. We will not tolerate it, we never have, and it is personally abhorrent to me.

Mr. Rogers. I share with you the concern. I am sure you do also. I think it would be helpful if you would have the AMA make comments to the committee—if you want to do it on a confidential basis, we have no objection—as to whether you think any action should be taken about it. I wish you would give some thought as to how we should have some mechanism for an appropriate review where there has been improper decisionmaking. We ought to have some mechanism to get at those problems; in other words, because as Dr. Carter said, I don't see any justification where there are four doctors for 16,000 people.

Mr. Carter. If you will yield, Mr. Chairman, I just feel like these gentlemen here were not conversant with what had happened down there.

Mr. Rogers. Yes; but what I am saying is, I hope they will look at these cases, and I think it will be helpful to give us some suggestions as to a mechanism for an appropriate review where there has been an unfortunate decision. I think we are going to have to face that.

Dr. Palmer. Yes, sir.

Mr. Rogers. Thank you. We appreciate your patience with this committee.

I would conclude our hearings. This committee stands adjourned.

(The following statements and letters were received for the record:)

Statement of the American Optometric Association

The American Optometric Association, a National organization representing nearly 18,000 members in fifty-one jurisdictions, appreciates this opportunity to express its views on H.R. 16755, the legislation to amend the Public Health Service Act for the purpose of improving the program of assistance to geographical areas experiencing health manpower shortages.

This association commends the members of the Subcommittee for its outstanding efforts to further improve the National Health Service Corps, a concept supported by the American Optometric Association when the Emergency Health Personnel Act of 1970 was considered by the 91st Congress. We still believe believe this program has great potential for relieving health manpower shortages, in those areas where optometric vision care is in short supply.

It is a matter of pride that members of the American Optometric Association have been serving in a professional capacity as officers of the U.S. Public Health Service Commissioned Corps since 1966. We find it encouraging that a strong likelihood exists of further increasing the numbers of optometrists in the Commissioned Corps. There is strong evidence that increased Commissioned Corps career opportunities, and the creation of the National Health Service Corps have served to generate a great deal of interest among health professions to provide health care in manpower shortage areas.

The American Optometric Association believes that H.R. 16755 is a worthwhile piece of legislation, but that it can be further strengthened by extending the scholarship provision contained in Section 225 of the bill to students of optometry as well as those in schools of medicine, osteopathy, and dentistry.

Consistent with the awareness of the need to include optometry students under the scholarship program, the American Optometric Association recommends the following amendments to Section 225 of H.R. 16755:

On page 10, line 10, after "osteopathy", strike out "and dentistry" and insert in lieu thereof ", dentistry and optometry"

On page 10, line 20 after "osteopathy," strike out "or dentistry leading to a degree of doctor of medicine, osteopathy, or dentistry or an equivalent degree, and" and insert in lieu thereof ", dentistry or optometery leading to a degree of doctor of medicine, osteopathy, dentistry or optometry or an equivalent degree, and "

On page 11, line 24, strike out "or dentistry" and insert in lieu thereof ", dentistry or optometry"

Adoption of these amendments to the bill would represent a major step toward providing a more nearly adequate number of optometrists to serve the vision care needs in communities which do not at present have convenient access to optometric services. Expansion of the scholarship program to include students of optometry, and subsequent involvement of a greater number of optometrists in the Commission Corps and National Health Service Corps will result in greater availability of professional vision care services in areas where there is such a critical shortage.

The AOA strongly urges approval of the recommended amendments by the subcommittee in order that all Americans will benefit.

Statement of Dr. John J. Walsh, Past President, Commissioned Officers Association of the United States Public Health Service

Mr. Chairman, I am Dr. John J. Walsh, Vice President of Health Affairs at Tulane University and past president of the Commissioned Officers Association of the U.S. Public Health Service. I am indeed grateful for the opportunity to present the views of the Commissioned Officers Association on H.R. 16755.

The Commissioned Officers Association of the U.S. Public Health Service represents approximately 4,600 members, which number includes 87% of the career active duty personnel of that Service. These members are physicians, dentists, scientists, engineers, pharmacists, nurses, veterinarians, dietitions, and others in the Commissioned Corps of the Public Health Service. The Corps is unique in

that its entire personnel is derived exclusively from professions in which individuals are trained outside the Service and qualified prior to commissioning.

Mr. Chairman, the Commissioned Officers Association supports H.R. 16755 and recommends its enactment. We firmly believe that the extension of the National Health Service Corps is vital to our Nation's health effort. We are convinced that this program, if properly financed and administered, can provide desperately needed health professionals and services in areas where such services are totally inadequate. Further, we support those provisions for scholarship and loan forgiveness programs for health professionals and guarantees to assure that our Public Health Service hospitals are not closed or transferred to community management without the close scrutiny and approval of Congress.

Mr. Chairman, we share your view that the Public Health Service hospitals should be utilized more broadly and in conjunction with the National Health Service Corps. Their activities should be made an integral part of the health resources of the communities in which they exist.

To make quality care available for all citizens will require the optimal utilization of our nation's resources. Attention must be directed to the improvement of all elements having an impact on delivery—efficiency, economy, effectiveness, etc. Newer types of health care personnel must be developed; alterations in the traditional roles of existing professionals must be considered and evaluated; educational programs must be improved and operated more efficiently; and our capability to maximize the contribution of categorical health workers must be strengthened. Also essential is the improvement of the health care system and subsystems, methods of financing care, facility efficiency and construction economy, materials and equipment standards etc.

Currently the Federal Government provides support for resource development and demonstration in the cited areas. The pattern that has evolved is one of scattered support to individuals and institutions for specific aspects of the total problem. While such an approach is productive there remains an acute need for a coordinated effort concerned with all facets of the health care delivery system. It stands to reason that a program conducted in a system composed of a limited number of research oriented hospitals has many advantages. They could be specifically oriented from conception through full operation to research development and demonstration activities related to the organization and delivery of health services.

At the present time the nation does not have a single institution let alone a system of health facilities totally dedicated to solving health care delivery problems. Yet, for a relatively modest investment, susceptible to a vast multiplier effect in results achieved, our national government could modify the PHS hospital system to perform these invaluable functions. It would contribute a unique laboratory in which the many concepts and solutions could be tested and evaluated.

The Public Health Service hospitals have a blend of patient clientel that compares most favorably with our national populations. These hospitals have long standing and deep roots in the health and academic affairs in diversified local communities. They are geographically located in areas with differing economic basis, ethnic groups, and health care problems.

The system is small enough to be managed efficiently. It has the capability to control the environment in which the research activities take place, and this capability is the sine qua non of research and demonstration in health care delivery. In essence I am advocating that the Public Health Service hospital system should continue to provide services to its beneficiaries but more importantly should be revitalized and continued as a limited number of research centers concerned with means and methods for improving the delivery of health care. From the moment of the conception of their rebirth the talents of economists, sociologists, psychologists, educators, architects, systems and industrial engineers and other specialists should be brought to bear in a unified action to achieving solutions to health care delivery problems. Should such a plan be activated and properly implemented one can anticipate significant results. Areas requiring study are practically limitless and range from experimental facility design and evaluation through financiug, management, personnel training and utilization to the more mundane but worthwhile efforts concerned with the evaluation of medical supplies and equipment. Highly specialized, total dedicated institutions such as I would envision the Public Health Service hospital becoming are currently nonexistent. Their cost and complexity render them impractical if not impossible to private and public organizations.

These hospitals and clinics also are ideal for serving as bases of support for the efforts of the National Health Service Corps. As ongoing institutions with appropriate support facilities and compliments of trained personnel, they offer immediate assistance at minimal cost. It seems most illogical to consider the closing of these hospitals as federal facilities and the dismemberment of their staffs under such circumstances.

An even broader and more basic consideration in the deliberations concerning the Public Health Service hospital is the growing role of the Federal Government in in all areas of health care. More than ever it does and will continue to need a cadre of highly competent career personnel to administer Federal Health Programs. The Public Health Service hospitals systems constitute an important resource for the recruitment, training and retention of such professionals.

Aside from the benefits accruing indirectly to the government, the Public Health Service hospitals have vital and long standing roles in the communities in which they exist. Responsibilities include broad community training programs of all types, medical assistance during disaster, community services such as acting as a regional poison control center, participation in various Office of Economic Opportunity and model cities programs, etc.

Finally their historical role of providing care to seamen and their care and treatment of civilian employees and Department of Defense personnel and their dependents are matters for consideration. In the case of seamen, one deals with a highly mobile population which has unique requirements in terms of conditions of care, e.g. short turn around time in port, need for obtaining care and hospitalization in a strange city for non-medically emergent, but occupational urgent reasons and the centralization of all care including dental care, etc. Also for many Department of Defense personnel these hospitals provide a source of care not otherwise readily available and although CHAMPUS costs are relatively modest, they do discourage some patients from seeking treatment.

In summary, then, I submit that while there are many reasons of variable importance, retention and revitalization of the Public Health Service hospital system is primarily warranted on its potential as a valuable and unique resource—one which will permit the federal goverdnment to make significant advances in health services research and development at minimal cost, with maximal results.

STATEMENT OF GEORGE M. BLATTI, NATIONAL PRESIDENT, STUDENT AMERICAN MEDICAL ASSOCIATION

Mr. Chairman, I am pleased to present to you, as President of the Student American Medical Association, testimony on H.R. 16755.

A basic tenet of the Student American Medical Association (SAMA) is that quality health care is a basic human right and should be equally available to all citizens regardless of geographical location. It is for this reason that SAMA has supported the objectives of the U.S. Public Health Service since 1968. In 1969, SAMA resolved itself to encouraging the expansion of the Public Health Service or other Federal programs in order to provide adequate continuous health care delivery to those areas which need them, utilizing community involvement and participation in planning, and to provide for an adequate influx of personnel especially through financial support for students in return for service in the Public Health Service. (Appendix A) With this brief summation of our involvement in and commitment to this program, I would like to thank you for this opportunity to present testimony with regard to the further expansion and continued growth of the National Health Service Corps.

One of the major issues now confronting the health care system is distribution of health services. Significant numbers of people live in areas which can be described as having "critical health manpower shortages" and we feel that P.L. 91–623, "Emergency Health Personnel Act of 1970," was a long needed step in the correction of this maldistribution problem. H.R. 16755 under consideration is another step in the rectification of this problem and will hopefully lead to the development of a more lasting solution. It is for this reason that we generally support H.R. 16755 with the following noted exceptions, suggestions and comments.

We suggest that the provision requiring the certification by the local government, the State and district medical society, or other appropriate health society, that health personnel are needed by the area be retained. This would enhance the involvement of the local medical societies and encourage cooperation, especially

when licensure and hospital privileges are under consideration. A cooperative environment is essential for the effective utilization of Corps personnel and all possible efforts should be made to assure and maintain such a working relationship. This is not to say that we endorse the exercise of an absolute veto power, pocket or otherwise, by any one person or group of persons. Therefore, we suggest that an appeal mechanism utilizing the National Advisory Council on Health Manpower Shortage Areas be established. This would offer some recourse for those communities which have either been denied designation as a critical health manpower area or have been denied certification that health personnel are needed for that area.

We wholeheartedly endorse the assignment of personnel on the basis of need and "without regard to the ability of the residents of the area to pay for health services." Section 23.5(a)(6) of the Rules and Regulations of the National Health Service Corps, as published in 36 Federal Register 242 dated December 16, 1971, and promulgated under P.L. 91-623, would seem to strike a blow at the very purpose of the Act by considering the "potential ability of persons in the area to pay the cost of providing health care services . . ." before designation of such area as having a critical manpower shortage.

With regard to the provision on charges, we believe the criteron used in determining the ability to pay for services in order to qualify for reduced rates or for no charge should be based on an annual income level higher than the current Social Security Administration poverty income level. This would qualify more people for at least reduced rates and further extend the availability of health care to those who cannot afford it. Further, we suggest that any funds collected under the Act be returned to the Corps program in a different fund and not be counted as part of the federal appropriations to the program.

Depositing such funds in the Treasury would seem only to avoid the possibility that areas would be selected on an ability to pay basis (a consideration of which has already been precluded earlier in these amendments) and we feel that more could be gained by a continued expansion and improvement of the program by the use of such collected funds. This would then demonstrate a definite long-term commitment of the government in fulfilling the purposes of the Act (under the present Act communities could lose the program next year and under the proposed amendments in three years) and we believe the communities would respond more favorably to the program if they could be made to realize that the government will not abandon them in their quest for adequate health care. HMO's and HSO's might provide a viable replacement, but until a workable system for the implementation of such organizations is devised, medically deprived areas should be made to realize that health care is and will continue to be available. In furtherance of HMO's and HSO's, we might comment that Corps project areas might further serve as prototypes of such organizations and be used to define possible problems and hopefully resolve a great many of them as they relate to direct health care.

We applaud the proposal of recruitment programs and recommend that SAMA be used as a valuable instrument in the dissemination of information on the program and serve as a contact point for representatives of the Corps—a task we would welcome. In as much as SAMA played a role in the development of the Corps, we would be eager to work for its expansion.

With reference to the establishment of guidelines with respect to how the Corps shall be used in designated areas, we feel that it fails to consider the recommendations of the communities so designated and should provide a mechanism for their participation in project discussions and local policy. While general guidelines for the overall use of the Corps are necessary in order to insure the purposes of the Act, each community has its own special problems. To insure consideration of those problems and to maximize the effective use of the Corps, each community should have a say in its own destiny.

The section regarding the preconditions before closing or transferring control of a hospital or other health care delivery facility further assures communities of the continuation of the program once established. Again, however, we would suggest that some sort of review or appellate procedure be established before such a facility is closed or transferred or, more importantly, before terminating or modifying an assignment of Corps personnel to an area. This would serve the purpose of bolstering public confidence even further and preclude possible arbitrary decisions. The National Advisory Council on Health Manpower Shortage Areas might well be utilized in this capacity as well.

The loan forgiveness program is most welcome. The social conscience of medical students has led many into the areas of public health, but we feel many have been deterred simply due to the fact that their financial situation at the end of their long and expensive studies does not allow them to follow the best dictates of their conscience. We feel that this accelerated repayment program affords the opportunity of making an unhampered decision and opens the doors to those highly qualified and highly motivated professionals who would opt to serve in the Corps.

We support the retention of the Section dealing with malpractice and negligence suits but would like to mention the fact that we do not endorse the erection of barriers in the path of the truly aggrieved patient.

Finally, we endorse the scholarship program, but recommend that every opportunity be given to the student to complete his professional training through residency before entrance into the Corps. This would allow an uninterrupted pursuit of his studies and further the purposes of the Act by eliminating the possibility that the person leave the Corps in order to return to his studies. We feel that this would offer a much higher retention rate in the long run.

Mr. Chairman, I thank you for this opportunity to comment on H.R. 16755.

APPENDIX A

Resolution No. 4A—Expansion of the Public Health Service 1969

Be it *resolved*, That it is the consensus of this meeting that the USPHS or other Federally-administered or approved programs be expanded to accept all interested and qualified volunteer medical and paramedical personnel into their ranks to provide adequate continuous health care delivery to those areas which need them, utilizing community involvement and participation in planning; and be it further

Resolved, that financial support be provided to medical and paramedical students while in school in return for service in the Public Health Service or the aforementioned organizations after graduation, in the same fashion as this is offered by the armed services; and be it further

Resolved, that this service would complete the national service obligation and that the real pay and privileges would be equal to that of military service; and be it further

Resolved, that the Student American Medical Association use its resources and powers of persuasion to see this brought before the Congress of the United States, enacted into law, and adequate funds provided for it, and that each SAMA chapter be encouraged by the National SAMA Office to send letters to the appropriate Congressmen and Senators of its respective district demanding affirmative action on this.

American Dental Association,
Washington, D.C., September 28, 1972.

Hon. Paul G. Rogers,
Chairman, Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: I am writing you on behalf of the American Dental Association with respect to H.R. 16755, the Emergency Health Personnel Act Amendments of 1972, introduced on September 21 and the subject of hearings on September 28.

I would be grateful if this letter could be made a part of the hearing record.

At the time the Act was being first considered, the Association expressed its concern over unequal distribution of dentists in some areas of the nation and its support for well-designed efforts to remedy that situation.

Under the present Act, a community or other local agency can survey its resources, decide whether it has a health personnel shortage and then, on its initiative, petition for the assignment of federal personnel to meet such shortage as may exist. This procedure seems to us to hold some promise of helping to solve, at least temporarily, problems arising from maldistribution.

It is not yet possible to know if the Act is actually fulfilling that promise. The time of operation has been too short for a reliable judgment to be made.

As the Committee is aware, initial appropriations were voted only some 14 months ago; implementing regulations were published only last December and just in recent months have personnel actually been assigned.

Given these circumstances, the Association is of the opinion that the Emergency Health Personnel Act should be merely extended without revision, such extension being coupled with the announced intent to hold oversight hearings in the coming year to gauge the program's successes and failures.

H.R. 16755 essentially takes the direction of simple extension and, in general, the Association supports it. There are, however, two departures from the present law that require comment.

The first change is with respect to the professional health groups with whom the Secretary must consult prior to approving the assignment of Corps personnel. Section 329b of the law presently requires such consultation with "the district medical societies (or dental societies, or other appropriate health societies as the case may be) . . ." It is proposed to change this to "the district medical societies in that area or by such other appropriate health societies as the Secretary may designate."

That change is, we think, for the worse and we oppose it. It should continue to be clear in the law, as it is now, that if assignment of a Corps dentist is in question, then the dental society is the professional health group that must be consulted. The fact that the Corps has thus far assigned only physicians or dentists strengthen our belief that the societies of both professions ought to be specifically lised in the law rather than leaving the selection of the group to be consulted to the discretion of the Secretary.

The second change proposed in H.R. 16755 about which we wish to comment concerns the method by which a manpower shortage area solicits the assignment of federal personnel. Presently, the law calls upon a community, in effect, to examine its resources and decide whether to call upon federal assistance for the services offered under the Act. The proposal would significantly shift that emphasis from the community itself to the Secretary.

We think this shift of decision-making is unwise. The number of requests for assistance that have been received indicate persuasively that local communities are fully capable of judging themselves and, when desired, taking the steps to request help.

Finally, the Association should like to comment on the new scholarship program for the Public Health Service Commissioned Corps proposed in Section 225 of H.R. 16755.

With the expiration of the draft law now anticipated, Congress and the Corps are to be commended for turning their attention to the recruitment problems they will face. We support the concept of a scholarship program as outlined in Section 225. We are concerned, however, with the degree to which that Section will be coordinated with similar federal programs now in existence.

Federal loans and scholarships for professional health students are now available under the Health Manpower Act of 1971, enacted last year under your leadership. In addition, the newly enacted H.R. 2 contains scholarship provisions of a similar nature for professional health students willing to join the uniformed services. Now a scholarship program is recommended for the Commissioned Corps. This provision is unrelated in large degree to the other provisions of H.R. 16755 since the scholarship recipients will not necessarily serve as assignees under the Emergency Health Personnel Act.

The Association does not oppose Section 225's enactment. We do believe, however, that the Committee should express its conviction that all steps to be taken to coordinate the programs as they are implemented in order to assure the most rational and productive use is being made of the nation's limited professional health manpower.

On behalf of the Association, I want to express our appreciation for having this opportunity to present our views on H.R. 16755.

Sincerely,

CARL A. LAUGHLIN, D.D.S.,
President.

American Academy of Pediatrics,
Evanston, Ill., October 4, 1972.

Hon. Paul G. Rogers,
Chairman, Subcommittee on Public Health and Environment, House of Representatives, Washington, D.C.

Dear Mr. Rogers: The American Academy of Pediatrics wishes to express its strong support for the Emergency Health Personnel Act Amendments now under consideration by the Subcommittee on Public Health and Environment and requests that the following comments be incorporated into the hearing record.

Since undertaking an extensive study on the delivery of health care to children in 1967, the Academy has been acutely aware of and deeply concerned by the problem of maldistribution of physicians and other health professionals. Among the major recommendations emanating from that study was the establishment of a voluntary, multidisciplinary National Health Service Corps as one step towards dealing with the critical health manpower shortages in sparsely populated rural areas and in crowded urban ghettos. The Academy was one of the first medical organizations to speak out in favor of the voluntary health service corps concept and would now urge both extension and expansion of that program.

The well-documented dearth of qualified health professionals in many areas of the country certainly justifies the continuation of the National Health Service Corps and indicates the need for expansion. In May, 1972, Dr. H. McDonald Rimple, Director of the National Health Service Corps, estimated that there are about 5,000 communities in the United States without any health care services. At present, approximately 144 areas have been designated as critical manpower shortage areas and have been assigned health personnel through this program, leaving several thousand communities still in need. While the National Health Service Corps is not intended to nor cannot hope to solve the problems in all of these areas, it can help to alleviate some of the most critical shortages that still exist.

One of the major reasons that many inner-city and rural communities have suffered a steady depletion of available health care services is that they cannot offer financial incentives to attract young physicians just going into practice. Under the Emergency Health Personnel Act Amendments of 1972, communities can apply for assistance regardless of their ability or inability to pay for services. Furthermore, the program will hopefully draw young physicians to these needy areas, not with financial incentives, but by tapping their great senses of social awareness, deep compassion for those in difficulty, great concern for injustice and seriousness of purpose. Through the recruitment process and scholarship stipends provided for in the proposed legislation, many of these young people will be brought into the Corps, where they will be given an opportunity to express their social concern and at the same time receive professional stimulation and continuing educational opportunities such that they will not be operating in isolation even when they are assigned to an isolated area. It is likely that some of these physicians and other health professionals will elect to stay and practice in the area of need to which they are assigned, and in this way service in the Corps may lead to a more permanent resolution of the community's health care shortage.

The problem of health manpower distribution is complex, and no one program should be regarded as a panacea. The National Health Service Corps is one of many alternatives which should be utilized to insure that adequate numbers of professional persons are available, accessible, and acceptable to those in need of care. Other means of solving the problem might include increasing the overall supply of physicians, making greater financial support available for medical education, and expanding allied health training programs. As an initial step towards reducing health manpower shortages, the concept of a voluntary health service corps should breed new approaches to the problem and become the cornerstone of a multidimensional effort to provide health care wherever it is needed.

Sincerely yours,

Jay M. Arena, M.D., *President.*

(Whereupon, at 5:15 p.m., the subcommittee adjourned.)

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